SCAN Consensus Project

# Inpatient Treatment of Drug and Alcohol Misusers in the National Health Service

Final Report of the SCAN Inpatient Treatment Working Party

The Specialist Clinical Addiction Network (SCAN) is a national network for UK addiction specialists. At present this includes Consultant Psychiatrists, Specialist Registrars and Associate Specialists who work in the field of addiction. Staff grade doctors in addiction psychiatry may be registered as affiliate members.

SCAN is funded by the Department of Health and jointly supported by the Department of Health, the Royal College of Psychiatrists and the National Treatment Agency for Substance Misuse, but is independent of all three agencies.

SCAN's main aims are to provide support and promote networking to enable specialists to maximise treatment effectiveness.

This document reflects the views of the inpatient consensus project working group and does not necessarily represent the views of SCAN or its sponsoring organisations, nor should this document be seen as representing official policy of any of the sponsoring organisations.



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# Foreword

Sharing of evidence-based practice is one of the fundamental objectives of the Specialist Clinical Addiction Network (SCAN). The SCAN Consensus Project Fund was established in 2005 by the Department of Health in recognition that although there is a lack of empirical evidence for some interventions and service models, there are areas of good practice and effective models in the treatment of addiction. It is known that there is variation in clinical practice and treatment provision nationally, and on some issues, a lack of consensus amongst addiction specialists on best practice. The SCAN consensus projects aim to facilitate the development of consensus within the field on pertinent clinical issues.

*SCAN Consensus Project: Inpatient Treatment of Drug and Alcohol Misusers in the National Health Service* has been written by a team of consultant psychiatrists in addiction who are experienced in the provision of NHS inpatient treatment. A multi-disciplinary steering group has been consulted and has contributed throughout the process. In addition, the document was open to public consultation via the SCAN and NTA websites and comments from a range of contributors including service users, service managers, commissioners and non-statutory providers informed the final document.

Developing consensus is never an easy task. With different practices, models and beliefs, finding common ground can be elusive. However, the development of this document has focused from the outset on achieving as wide a consensus as possible. The final report is a credit to the commitment of the working party to this process. Though the report describes optimal provision in the NHS, other providers of inpatient care may find the document useful. It is our hope that the document will also assist commissioners in further understanding of the role of inpatient treatment in the wider addiction treatment system.

Inpatient treatment for drug and alcohol misusers is often inappropriately viewed as simply 'detox'. This report clearly shows that service users need a great deal more than that in a comprehensive package of care designed to meet their needs. For that reason you will not find the term 'detoxification' anywhere in this report.

It is hoped that the report will help to shift perceptions of what inpatient services of the future should look like.

Professor Colin Drummond
SCAN Lead

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# Inpatient Treatment for Drug and Alcohol Misusers

# Executive summary

This document is the result of a project initiated and managed by the Specialist Clinical Addiction Network (SCAN) in conjunction with its stakeholders, the Department of Health (DH), the National Treatment Agency for Substance Misuse (NTA), and the Royal College of Psychiatrists (RCPsych). It was conceived as a short timeframe piece of work that would inform service providers about how best to configure inpatient units (IPUs) within the National Health Service (NHS) to meet the needs of their service user groups, and act as a template for commissioners interested in purchasing such services in a locality/region. This work is therefore aimed to support the NTA's Tier 4 strategy.

- A project working group was assembled consisting of six addiction psychiatrists with experience of clinically managing specialist IPUs in the NHS in England
- A project steering group was independently chaired and involved key stakeholders (DH, NTA, RCPsych). It also invited representatives from key professional groups (e.g. medical, nursing, psychology) and service user and carer representatives
- The working group produced a total of four drafts of the document, and each was presented at and commented on at a meeting of the steering group. The document was also disseminated widely through the SCAN and NTA websites, and comments were received from psychiatrists, general practitioners, IPU managers, non-statutory service providers, pharmacists, and service users
- The project was to consider inpatient services for adults (over 18 years old) provided by the NHS. This project was not intended to apply to addiction residential rehabilitation services, which are the subject of a separate exercise currently being conducted by the NTA. However, residential rehabilitation services that provide residential assisted withdrawal facilities may find this document useful
- It is anticipated that the recommendations produced could also apply to IPUs commissioned in the private sector

# 1. Introduction

This document sets out the ideal configuration for IPUs for adults, outlining the resources required in terms of buildings, staffing, and training, and suggesting ways of interfacing with community services. It emphasises the importance of the IPU as part of a wider treatment system. An IPU should not be seen as an alternative to community provision, but rather should enhance the delivery of such services by providing targeted work with service users with severe and complex problems.

### 1.1 Definition of an IPU

- The key feature of an NHS IPU is the provision of assessment, stabilisation and/or assisted withdrawal

with 24-hour cover from a multidisciplinary clinical team who have had specialist training in managing addictive behaviours

- The clinical lead in such a service comes from a consultant in addiction psychiatry or another substance misuse medical specialist
- The multi-disciplinary team includes psychologists, nurses, occupational therapists, pharmacists, social workers, and other activity, support and administrative staff
- IPU treatment programmes include a wide range of prescribing and psychosocial interventions, as well as physical and mental health screening, harm reduction interventions, and relapse prevention work. As such they are intended for those alcohol or drug users whose needs require supervision in a controlled medical environment
- In defining an IPU it is helpful to make a distinction between "medically monitored" and "medically managed" residential treatment:
  - Medically monitored treatment: this can be provided in non-acute medical settings such as residential rehabilitation services, and is most appropriate for individuals with lower levels of dependence and without a range of associated medical and psychiatric problems
  - Medically managed treatment: this is typically provided in a hospital environment (i.e. NHS IPUs), and is the subject of this report
- There is no reason why residential rehabilitation services could not provide medically managed care, but in order to do so the principles of best care outlined in this report would need to be met

### 1.2 The current picture

- The current delivery of IPU services for people with drug or alcohol problems in the UK is not systematic, and the process by which a service user can access an inpatient service shows no uniformity across the country
- There is a huge disparity between services in terms of input from specialist staff, and few have a truly multi-disciplinary team
- The range of treatment and other services on offer varies enormously from unit to unit
- A minority of services admit service users for non-abstinence focused treatment, and even established harm reduction interventions (e.g. screening and vaccination services for blood borne viruses or training for service users in managing drug overdose) are not provided routinely in the majority of services
- Many IPUs are not integrated into the overall treatment service, as approximately one third do not require service users to have a post-discharge treatment plan in place prior to admission
- Links to pre-admission or post-discharge treatment services are often poor

### 1.3 The place of IPUs in the treatment system

- When considering the treatment system as a whole, it is useful to draw a distinction between "placement matching" and "modality matching":

  - Placement matching: where a service user is referred to a particular setting, such as intensive outpatient or residential care
  - Modality matching: where a service user's needs are matched to a specific treatment approach (e.g. motivational enhancement therapy), regardless of the setting

- When placement matching is disconnected from modality matching, treatment is likely to be less effective because it fails to respond to the individual needs of the service user

- Good treatment planning combines modality matching (for all pertinent problems identified in the assessment) with placement matching (which identifies the least intensive level of care that can safely and effectively provide the resources that will meet the service user's needs). This is sometimes referred to as "stepped care"

- A care plan developed in agencies providing either Tier 2 or Tier 3 interventions should utilise an IPU (or residential rehabilitation) environment if it is the most suitable place to achieve a particular goal efficiently and successfully

- In order to tailor an inpatient intervention to the service user's needs, there should be considerable flexibility in the length of admission

- The key feature of an IPU is the provision of specialist multi-disciplinary care, available 24 hours per day and delivered in a safe, alcohol or drug-free environment with ready access to other medical or psychiatric hospital services

- An IPU can be used for three broad groups of tasks – assessment, stabilisation and assisted withdrawal – and as such should be part of any integrated treatment system. The medically managed IPU can deliver care-planned interventions to service users at any point in their treatment career, but when the focus of an IPU is only on assisted withdrawal, service users who could derive a health gain from such a service are often excluded

### 1.4 Specialist and general settings

- There are currently twice as many drug IPU services that consist of a few beds on a general psychiatric ward than there are stand alone specialist services. The situation for inpatient alcohol treatment is less clear, but it is likely that this ratio is even higher

- When compared with specialist services, general ward-based services have:
  - fewer beds per service
  - lower bed occupancy
  - shorter planned and actual admission periods
  - a greater likelihood of being closed or unavailable
  - less input from staff that specialise in the treatment of substance misuse problems
  - a narrower range of available medical and psychological treatment options

- This report recommends that dedicated NHS specialist services are the optimal setting for the delivery of inpatient treatment to service users with severe alcohol or drug problems

# 2. The services that a good IPU can provide

## 2.1 The key features of an IPU

- An IPU provides care to service users with substance-related problems that are sufficiently severe and/or complex that they require medical, psychiatric, and psychological care 24 hours a day
- An IPU is staffed by a multidisciplinary team with specialist knowledge of the management of addiction
- IPU treatment is based on a plan of care, developed prior to admission, and should encompass relevant preparatory work and a seamless transition to on-going treatment after discharge
- The treatment provided by an IPU is:
  - individually tailored
  - flexible
  - able to make use of a menu of pharmacological, psychological and social interventions
  - specific to mental and substance-related disorders
- The skills of the IPU multidisciplinary team and the availability of support services allow the conjoint treatment of any co-occurring medical or psychiatric conditions
- The full resources of a general acute care hospital or psychiatric hospital are available to the IPU, either directly (on the same site) or indirectly (through consultant referral). This may include medical, surgical, antenatal, dental advice and care, or dietary, or pharmacy advice
- An IPU treatment programme incorporates activities and services beyond the medical or psychological treatment process (e.g. employment, housing, social activities), and therefore plays an important role in social re-integration
- Although admissions to IPUs are voluntary, treatment incorporates a set of policies and procedures that set boundaries on behaviour (e.g. non-prescribed drug use), while enabling service users to be treated in an empathic and therapeutic manner

## 2.2 The core work of an IPU

### *2.2.1 Assessment*

- Individuals with drug and alcohol dependence present with a wide range of psychiatric, physical and social problems
- Substance misuse services provide a comprehensive assessment of these needs and formulate a treatment care plan to tackle them
- A hospital setting permits a higher level of medical observation, supervision and safety for service users needing more intensive forms of care. Specific tasks of the IPU may include:
  - assessment of substance use
  - assessment of mental health
  - assessment of physical health
  - assessment of social problems

*2.2.2 Stabilisation*

- There is considerable evidence that the number of service users with more complex problems (co-existing physical and mental illness, dependence on more than one substance) is increasing. Such cases can be managed in a community setting, but the IPU setting permits a high level of medical observation, supervision and safety for service users needing more intensive forms of care

- IPUs have become focused on assisted withdrawal by default, with a perceived focus on abstinence-based treatment goals. The IPU should have care pathways, clinical protocols, and sufficient human and physical resources to offer the following range of stabilisation procedures:

  1. Dose titration
     - Admission to an IPU with staff skilled in monitoring the effects of methadone and the opioid withdrawal syndrome may prevent the individual dropping out of treatment, or else continuing to supplement their prescribed methadone or buprenorphine dose with illicit opioids

  2. Dose titration on injectable opioid medication
     - IPU admission allows interventions to optimise the service user's injection technique, and 24 hour monitoring allows safer and more efficient calculations of dosage

  3. Stabilisation on maintenance therapy
     - Use of heroin on top of a prescription of methadone can be problematic, and attempts to tackle it in the community may lead to increasing doses of methadone and rising opioid tolerance without the desired break from the illicit drug market
     - A short (one or two week) admission to an IPU may be an effective way of breaking this cycle, particularly when followed up by day care or intensive community support

  4. Combination assisted withdrawal/stabilisation
     - A period of IPU treatment may allow assessment and treatment of the withdrawal symptoms from stimulant drugs, alcohol or benzodiazepines, and in doing so facilitate stabilisation on opioid maintenance treatment. Such individuals can then continue to receive Tier 3 interventions in a community setting

*2.2.3 Assisted withdrawal*

- Assisted withdrawal is popular with service users, possibly because some believe that this is all they need to do to achieve abstinence from drugs and to remain drug-free

- However, attempts to treat alcohol or drug addiction by means of assisted withdrawal alone have repeatedly been shown to have high rates of relapse to dependent use

- Assisted withdrawal should therefore only be encouraged as the first step in a longer treatment process, and needs to be integrated with relapse prevention or rehabilitation treatment programmes which can be provided in the NHS or independent/non-statutory sector

- Withdrawal in an IPU setting offers better opportunities for clinicians to ensure compliance with medication and to manage complications. IPU admission also offers a major opportunity to recruit service users into longer-term treatment to reduce the risk of relapse back into regular drug or alcohol use

- The IPU should have care pathways, clinical protocols, and sufficient human and physical resources to offer assisted withdrawal for the following problems:
  - alcohol
  - opioids
  - stimulants
  - benzodiazepines
  - cannabis
  - combinations of the above
  - other drugs

### 2.3 Other important functions

#### *2.3.1 Psychological interventions*

- Strategies based on psychological models of addiction play a crucial part in all stages of a treatment pathway, including engagement, assessment, maintenance, assisted withdrawal, and prevention of relapse

- In order to achieve optimum efficacy, IPUs need to integrate psychological interventions into all aspects of their work

- A mix of cognitive and behaviourally driven approaches is often best, and all psychological therapy should be individually tailored. Group therapy is effective and may provide benefits in terms of peer support, but is not suited to everyone

#### *2.3.2 Other activities*

- In order to deliver a comprehensive care package, medical and psychological approaches should be supplemented by occupational and "social" interventions

- Individuals with problems at a level that requires an IPU admission are likely to also be experiencing difficulties in housing, work, and relationships. Planned activities on the IPU can be an excellent way of assessing these deficits and developing a plan of intervention

- Boredom is a major risk factor for relapse to problematic patterns of alcohol or drug use, and so it must be addressed in the IPU. Providing opportunities for mental and physical activity distract the individual from unpleasant withdrawal symptoms, and can be used as a way of gaining new skills to be used after discharge

#### *2.3.3 Harm reduction issues*

- A period of IPU treatment means contact with the service user for 24 hours a day, 7 days a week, and as such provides a valuable opportunity to deliver a range of interventions aimed at reducing harm.

1. Testing for and vaccination against blood borne viruses
   - Testing for hepatitis B, C and HIV, and hepatitis B vaccination should be provided for any at-risk service user during an IPU stay

2. Training in drug overdose prevention
   - Drug overdose continues to be one of the most frequent causes of death among drug misusers and increased rates of fatal overdose have been reported among recently abstinent opioid addicts
   - Increasing overdose awareness and the provision of take-home emergency supplies of naloxone could prevent many opioid overdose deaths
   - Training covering overdose information, risky situations, recognising an opioid overdose, and the delivery of basic life support techniques, should be given to all service users undergoing an assisted opioid withdrawal programme

3. Prevention of Wernicke-Korsakoff syndrome
   - Service users admitted to an IPU for medical management of alcohol withdrawal are at high risk of developing Wernicke-Korsakoff syndrome
   - IPUs must be equipped to provide prophylaxis and treatment for this condition. Oral thiamine is ineffective in this condition. Therefore, appropriate facilities for parenteral thiamine treatment are necessary, including facilities to manage the rare cases of anaphylaxis that may occur

4. Healthy lifestyle advice and smoking cessation interventions
   - Promoting a healthy lifestyle requires discussion with the service user about their daily living habits and their motivation and desire to change them. Access to a specialist dietician service is important in delivering these interventions
   - Smoking is the single greatest cause of preventable illness and premature death in the UK. Effective smoking cessation strategies should be offered to all smokers

5. Access to dental assessment and treatment
   - Dental problems are common among heavy drug and alcohol-using populations, and access to specialist dental care during an IPU stay may be a beneficial harm reduction measure

### *2.3.4 Relapse prevention work*

- The process of assisted withdrawal should not in itself be expected to lead to the changes that provide sustained abstinence. There remains a further need to tackle the problems of psychological dependence, as this can lead to relapse after assisted withdrawal, even after prolonged periods of drug-free functioning

- Naltrexone may be useful for some opioid dependent service users, particularly if they have a strong personal motivation to take it, have a supportive family member, are employed and have a short opioid-using history

- Disulfiram, acamprosate and naltrexone may all prove beneficial in reducing the risk of relapse to heavy alcohol consumption after a period of assisted withdrawal

- Relapse prevention training uses a variety of behavioural and cognitive strategies to identify high risk situations for return to alcohol or drug use and to equip the user with the skills to reduce the risk of relapse

- It is useful to form links with Alcoholics Anonymous (AA)/Narcotics Anonymous (NA) groups, as AA or NA attendance may form part of a treatment care plan post-discharge or else as part of an aftercare package. Twelve step facilitation, in which engagement with AA is encouraged, also has proven efficacy in treating alcohol dependence

# 3. Delivery issues

## 3.1 The interface with other parts of the treatment system

### *3.1.1 Preparation for admission*

- In order to optimise the utility of the IPU environment, and to integrate it fully into the treatment care pathway, far more attention needs to be paid to pre-admission work
- Unrealistic goals may be set by community services with differing philosophies of care to the IPU, and service users may also set themselves goals that are hard to achieve as they feel they have no other therapeutic option
- There must be an emphasis on the development of integrated care pathways into (and out of) IPUs, with an emphasis on formal relationships, effective joint working and agreed joint protocols between referral sources and the IPU
- Such an approach also requires a review of current waiting times for IPU treatment, with recognition of the value of preparation time as part of the intervention
- The key considerations for the pre-admission process are:
  - Providing information describing the unit and the treatment processes offered
  - Liaison with referring agencies, the service user and their carers to establish clear goals of the admission and approximate likely duration
  - An initial assessment done prior to admission by a member of the IPU
  - An initial pre-admission visit to the IPU to see the environment and meet the staff can reduce anxiety in service users and increase the likelihood of engagement
  - Pre-admission education and counselling work is essential to optimise potential benefits from the period of IPU admission
  - Advance consideration of funding, travel and other issues

### *3.1.2 Linking IPU treatment to post-discharge care*

- The assessment information obtained or the treatment gains made during IPU admission can be lost if they are not followed-up immediately upon discharge
- The length of treatment should be determined by service user need, with the possibility of longer stays where indicated (e.g. in pregnancy)
- A choice of post-discharge care packages should be available to allow individually tailored treatment according to care-planned need
- The system must be flexible, as the service user's goals often change as symptoms of substance withdrawal, physical, or mental illness are brought under control
- Provision needs to include both abstinence and non-abstinence based settings and will be different for

service users accessing the different pathways within the IPU (i.e. assessment, stabilisation, assisted withdrawal)

- Referring agencies should be actively involved before, during and after an IPU admission, but there is also a role for staff attached to the IPU in facilitating continuity of care
- Where a treatment plan includes pharmacotherapy, this should be commenced before discharge. There must be seamless provision for continued prescribing and monitoring of this treatment by an addiction specialist spanning the transition from IPU to further community or residential treatment
- It is important to involve the service user's family and wider social network in their IPU treatment plan, in order to develop support for post-discharge treatment goals

### 3.2 The service user and carer perspective

- Treatment responsive to the needs of service users is more likely to facilitate treatment retention and good outcomes
- IPUs should provide good quality information for service users about the unit, treatment pathways, policies, and expectations
- Service users should expect to have access to an IPU with the full range of facilities and should expect to have a comprehensive post-discharge plan
- Each service user must have a role in drawing up their care plan prior to the admission and in reviewing it during the admission
- As part of their post-discharge care function, IPUs should facilitate service user support groups
- IPUs should have procedures and policies to support ex-service user involvement as volunteers with routes into paid employment
- IPUs should also encourage service user involvement in service planning and development
- IPUs should carry out regular service user satisfaction surveys and act on the results

### 3.3 Staffing

- The service provided by an IPU is dependent on skilled and motivated staff
- The service should be staffed by a multi-disciplinary team with specialist training in the assessment and management of addictive behaviours
- In NHS settings a specialist doctor at consultant level (responsible medical officer or RMO) will provide clinical leadership to such a team, but management leadership may come from any of the other professional groups

- The exact configuration of the clinical team will depend on the:
  - available financial resources
  - ability to recruit specialist staff
  - needs of the service user group served by the IPU
  - the goals of treatment

### 3.4 Training

- Despite the high levels of clinical skill needed, there are currently no agreed training requirements or recommended educational pathways for staff working in IPUs
- The principles of the Drug and Alcohol National Occupational Standards (DANOS) should be adapted to develop specific competencies for specialist IPU staff
- Consideration should be given to apprenticeship and rotational training schemes for junior staff that incorporate IPU experience
- Staff rotation between inpatient and community services would be particularly advantageous from the perspective of both training and service provision
- Each IPU should have written clinical protocols, a unit handbook and an operational manual
- Service users and carers should be involved in in-house training where possible
- Regular clinical supervision is essential for the delivery of evidence-based interventions
- Staff appraisal must occur on a yearly basis and identify training needs

### 3.5 Environment

- There is a role for the multidisciplinary team and service users and their carers in the design of IPUs
- Although local issues such as the size of the unit, its location, and its catchment area population will influence the exact arrangement, there may be advantages if:
  - beds for service users with primary alcohol and primary drug problems are separated (i.e. on different wards of the unit)
  - beds for assessment/stabilisation work and assisted withdrawal programmes are separated (i.e. on different wards of the unit)
- Ideally wards within IPUs should have no more than 15 beds
- The population served by a 15-bed unit will depend on the local prevalence of alcohol or drug dependence, the level of community and other medical and services, and the degree of integration of local care pathways. However, a ratio of 15 beds (for both service users with primary alcohol and drug problems) per half a million total population is appropriate
- Commissioning arrangements will vary depending on location:
  - Cities with a population of between 250,000 and one million people may be well suited to having a single stand-alone unit, as it is likely to be in easy reach of most of the population

- London and large conurbations will require several large units in order to make access as easy as possible for the largest percentage of its catchment population
- Large rural areas may need a hybrid approach. This could involve a number of smaller specialist wards within psychiatric or acute medical hospitals forming a wider regional network

- IPUs should be located to allow for ease of access to a general hospital

- IPUs should be as spacious as possible, with outdoor space available

- Consideration should be given to providing female-only units or female-only sections of mixed units

- All units should have:
  - well equipped clinical examination rooms
  - well equipped consulting rooms ensuring privacy
  - a supervised urine testing room
  - a dispensing room with a way of separating staff from service users during dispensing
  - a large group room
  - a room for family visits (including play equipment)
  - a designated staff room with personal lockers, shower and toilet facilities, and an area for refreshments and private time
  - disabled access

### 3.6 Special populations

#### *3.6.1 Black and minority ethnic groups*

- IPUs should be aware of the mix of ethnic and cultural groups present in the population that they serve

- IPU staffing should reflect that of their target populations, and staff should have an understanding of relevant cultural issues

- Community consultation should be part of IPU planning initiatives, and the IPU environment and programme should respect different cultural beliefs and practices

#### *3.6.2 Young people*

- It is usually inappropriate to place a person under the age of 18 in a facility designed for older people and so development of inpatient facilities for this group needs to be considered by the commissioning process in each area of the country

#### *3.6.3 Older adults*

- As the population ages, addiction problems will become increasingly prevalent in older adult groups and IPUs may need to tailor medical, psychological and social treatment packages to the needs of older people

*3.6.4 Pregnant women*

- It is important to address the needs of both the mother and the foetus, and IPU treatment allows for accurate assessment and dose titration, opportunities to address drug or alcohol use, engagement with antenatal care services and assisted withdrawal where appropriate
- The IPU should allow for joint working with the woman's partner and/or family, in order to address social and psychological needs as well as the treatment of the woman

*3.6.5 Comorbidity of physical illness and substance misuse*

- Acute medical problems require management in a hospital setting, but substance misuse IPUs have a role in supporting acute services and primary care in assessing and managing physical comorbidity in this vulnerable group
- IPUs should develop a staff group with a high level of expertise in assessing and managing physical problems, and be well equipped in terms of physical resources and environment

*3.6.6 Comorbidity of mental illness and substance misuse*

- Service users with severe and enduring mental illness and substance misuse should have their care primarily managed by mental health services, in line with national guidance. However, IPUs have a role in supporting such services through the assessment and on-going management of the co-existing substance misuse problem
- A majority of service users presenting to community substance misuse treatment services have other mental health problems, most commonly depression, anxiety or personality disorders. Such disorders may be difficult to assess and treat in a community setting, particularly if alcohol or illicit drugs are used as a form of self-medication

**3.7 Policies and procedures**

- IPUs require clear and specific procedures in order to provide a safe and therapeutic environment for treatment
- Service users should be well informed about the unit's treatment programme, policies and procedures, and should be able to agree to them as a condition of admission
- The unit policy should expect all service users to participate in the treatment programme except for those who are judged to be too unwell by unit staff
- Admission will also require undertakings not to use non-prescribed drugs or alcohol and to refrain from unacceptable behaviour (e.g. actual or threatened violence, racist or other discriminatory talk or behaviour)
- Service users will also be expected to refrain from behaviour that puts others at risk of relapse
- Consideration must be given to issues surrounding:

- access to visitors
- use of non-prescribed drugs, alcohol and tobacco
- drug testing
- unplanned discharge
- involvement of the police where illegal activity has taken place (e.g. drug dealing, assault)
- re-admission to the IPU
- child protection issues
- ex-users as staff
- volunteers

### 3.8 Quality assurance

- Each IPU must be integrated into a wider clinical governance structure to ensure that progress is made across all seven domains outlined in *Standards for Better Health*[1]

- Progress towards the recommendations made in section 3 of this document should be continuously monitored through the clinical governance framework of the IPU parent organisation (usually an NHS Trust)

# Background and aims

This document is the result of a project initiated and managed by the Specialist Clinical Addiction Network (SCAN) in conjunction with its stakeholders, the Department of Health (DH), the National Treatment Agency for Substance Misuse (NTA), and the Royal College of Psychiatrists (RCPsych). It was conceived as a short timeframe piece of work that would inform service providers about how best to configure NHS inpatient units (IPUs) to meet the needs of their service user groups, and act a template for commissioners interested in purchasing such services in a locality/region. The report was to consider both primary drug users and primary alcohol users, and it was anticipated that it would inform the NTA Tier 4 Strategy launched in Spring 2006.

The project lead was identified in October 2005 and a project working group was assembled consisting of five other psychiatrists with experience of clinically managing specialist IPUs in England (see appendix 3).

A project steering group was invited by SCAN to attend an initial meeting in London on 29 November 2005. This was independently chaired and involved key stakeholders (DH, NTA, RCPsych). Representatives from key professional groups (e.g. medical, nursing, psychology) and service user/carer representatives were also invited. The steering group finalised the scope of the project, and the working group then produced a draft report, *Inpatient treatment of drug and alcohol misusers*, in early February 2006.

The first draft of the document was reviewed by the project steering group and discussed at a meeting at SCAN on 17 February 2006. Revisions were made to incorporate the feedback from the group, and version two was disseminated to the full SCAN membership by e-mail in early March 2006. Feedback from this wider consultation process was presented at the third meeting of the project steering group on 21 March 2006, and informed the project working group in preparing the third version of the document. A further four-week consultation period then followed, where the document was posted on the SCAN and NTA websites and comments were sought from a wide range of stakeholders. During this period comments were received from psychiatrists, general practitioners, IPU managers, non-statutory service providers, pharmacists, and service users. This feedback was presented to the steering group at their final meeting on 12 May 2006, and the document was revised in the light of comments received.

The project was to consider inpatient services for adults (over 18 years old) provided by the NHS. This project was not intended to apply to addiction residential rehabilitation services, which are the subject of a separate exercise currently being conducted by the NTA. However, residential rehabilitation services that provide residential assisted withdrawal facilities may find this document useful.

The project working group was asked to address the following questions:

- What are the aims and objectives of IPUs (e.g. assessment, stabilisation, assisted withdrawal)?
- What are the appropriate elements of IPUs?
- How should they be delivered?
- Who needs them? (Inclusion and exclusion criteria)
- How should they be integrated into the system of care? Where do IPUs fit into the "treatment journey"?

- What constitutes best clinical practice in IPUs? (e.g. appropriate length of stay, range of psychological and pharmacological interventions, wrap around services)
- What is the evidence for effectiveness of IPUs?
- What are appropriate settings and configurations for IPUs? (e.g. regional versus local, specialist versus general psychiatric unit)
- What constitutes appropriate staffing, competencies, and management of IPU treatment?
- Management of special groups (e.g. comorbid mental illness, pregnant women, young people)
- Differences in provision for urban, rural, metropolitan areas
- Can we describe a model service in a "typical" area, including number of beds, staffing etc?
- What are the current key barriers to implementation of best practice?

# 1. Introduction

This document sets out the ideal configuration for NHS IPUs, outlining the resources required in terms of buildings, staffing, and training, and suggesting ways of interfacing with community services. In doing so it has tried to focus on describing best clinical practice, outlining the optimum configuration for services. However, it is acknowledged that the actual organisation of services in a particular locality will depend on a wide variety of factors, and that there may be a large gap between current practice and the aspirational approach of this document. Wherever possible, potential solutions for bridging this gap have been suggested.

The document comes from the perspective of medical practitioners with extensive experience of working in NHS IPUs, but seeks to emphasise the importance of a specialist, multidisciplinary approach. The central tenet of the argument for developing NHS IPUs is the ability to provide an environment where an individual with severe and complex problems can receive a targeted package of interventions to tackle these issues more effectively than could be achieved in the community. Furthermore, this comprehensive approach to assessment and management can be delivered with a greater intensity and with greater protection from outside forces (such as pressures to continue substance use) than could ever be managed in a community setting.

The working group wished to emphasise the importance of the NHS IPU as part of a wider treatment system. The IPU should provide a range of services complementary to, and integrated with, community services. It should not be seen as an alternative to community provision, but rather should enhance the delivery of such services by providing targeted work with service users with severe and complex problems. This document argues for greater flexibility in the use of the IPU setting, viewing it as one of the tools available to community-based services to assist their service users in achieving their care-planned goals.

This project focuses on adults of working age (18-65 years), but the authors acknowledge that similar services are also necessary for young people (under 18 years) and older adults (over 65 years). It was felt to be inappropriate that adult services should be used for young people and that consideration of the need for services for this population is a large piece of specialist work in its own right. Likewise, services need to adapt to an ageing population where alcohol and drug problems are often undetected and poorly managed.

### 1.1 Definition of an inpatient unit

Treatment in a residential setting may involve stabilisation, assisted withdrawal, rehabilitation, a combination of all three, or one followed by the other[2]. This may last anywhere between one week and one year[3]. The key feature of an NHS IPU is the provision of these services with 24-hour cover, 7 days per week, from a multidisciplinary clinical team who have had specialist training in managing addictive behaviours. The clinical leadership in such a service comes from a consultant in addiction psychiatry or other medically qualified substance misuse specialist[4], and the multi-disciplinary team includes psychologists, nurses, occupational therapists, pharmacists, social workers, and other activity and support staff. Programmes are intended for those alcohol or drug users who need supervision in a controlled medical environment and include a wide range of prescribing and psychosocial interventions, as well as physical and mental health screening, harm reduction interventions, and relapse prevention work.

Some residential rehabilitation services provide assisted withdrawal services, and it is helpful to make a distinction between "medically monitored" and "medically managed" residential treatment (see box 1, page 26). The former can be provided in settings such as residential rehabilitation services or crisis intervention

units, and is more appropriate for individuals with lower levels of dependence and without a range of associated medical and psychiatric problems. People with severe and/or complex alcohol and drug dependence are more appropriately and safely treated in environments that are hospital-based (i.e. NHS IPUs), which is the subject of this report. While residential rehabilitation services typically provide medically monitored care, they could equally provide medically managed care, provided that the principles of best care outlined in this report are met. All references to "IPU treatment" or "inpatient services" in the report refer to treatment in an NHS IPU setting.

## 1.2 The current picture

### *1.2.1 Drugs*

The current delivery of inpatient treatment for people with drug problems in the UK is not systematic[5]. Inpatient beds are commissioned in a variety of ways, with some facilities serving just one drug action team (DAT) and others providing beds for as many as 100 DATs. Inpatient beds are located in a variety of settings, ranging from purpose-built specialist units to beds on general psychiatric or medical wards. The physical environment is not always suitable for the service user group.

In terms of input from specialist staff there is huge variation in services, and few have a truly multi-disciplinary team. Medical leadership is most often provided by a consultant psychiatrist, but the number of hours per week provided is inconsistent across services, and some do not have any regular medical support. Day-to-day care is provided by a range of professional and non-professional groups, with many services not employing any staff with specific training in managing substance misuse problems. Staffing shortages are a significant problem in many units.

The process by which a service user can access an IPU shows no uniformity across the country, with some services giving direct access to a range of agencies and others requiring individuals to meet a number of admission criteria that are not necessarily related to the service user's needs (e.g. the need for urgent stabilisation of drug use in pregnancy). Once admitted, the range of services on offer is equally variable, and the average length of admission for assisted withdrawal ranges from 4–77 days[5]. Although many services acknowledge that a significant proportion of the service users admitted to their beds have problems with poly-substance use, the focus of most treatment appears to be opioid dependence. Service users are also likely to experience differences in the amount and variety of structured psychosocial treatment provided depending on the service that they access. A minority of IPUs admit service users for stabilisation or non-abstinence focused treatment, and even established harm reduction interventions (e.g. screening and vaccination services for blood borne viruses or training for service users in managing drug overdose) are not provided routinely in the majority of services.

IPUs estimate that 70–85 per cent of admissions achieve their inpatient assisted withdrawal goals and 45–65 per cent achieve stabilisation goals. However, in most cases these results represent the best guess of the person completing the questionnaire and very few services have produced good quality audit or research data about their work. Furthermore, many IPUs are not integrated into the overall treatment service, as approximately one third do not require service users to have a post-discharge treatment plan in place prior to admission. There are also limited links to post-admission or post-discharge treatment services, with only one-third of service users discharged to residential or day care rehabilitation services. Not all IPUs are part of clear treatment pathways[5].

### *1.2.2 Alcohol*

Specialist IPU treatment provision is important to address the needs of alcohol dependent individuals with severe and/or complex problems. Such problems need careful and comprehensive assessment and the treatment designed to address identified needs should be based on evidence. Specialist IPUs are an important repository of high-level knowledge and expertise in the alcohol and drug fields[6]. The widespread closure of regional inpatient alcohol units in the 1990s was associated with a net loss, nationally, of expertise in treating alcohol dependence. The training function of these units was also lost, and with it the skills of a generation of clinicians. Paradoxically this loss of skills took place at a time when national alcohol consumption and alcohol problems were on the increase. Research on treatment outcomes for alcohol dependence indicates that prognosis is influenced by service user attributes, treatment and the treating clinician. In England there is a wide gap between the need for alcohol treatment and access to that treatment, with only one in eighteen (5.6 per cent) alcohol dependent individuals accessing specialist treatment nationally each year[7]. In North America, an access level of one in ten (10 per cent) alcohol dependent individuals entering treatment each year is regarded as a "low" level of access.

## 1.3 The place of inpatient units in the treatment system

*Models of Care for the Treatment of Adult Drug Misusers* provided a conceptual framework to aid rational and evidence-based commissioning of drug (and alcohol) treatment in England[8]. Services for substance misusers were grouped into four broad bands or tiers. Inpatient drug or alcohol misuse treatment was defined as a "Tier 4 service" within *Models of Care* (2002), and was bracketed with residential rehabilitation agencies under Tier 4a. Highly-specialist, non-substance misuse specific services such as liver units and forensic services for mentally ill offenders were labelled as Tier 4b. *Models of Care for the Treatment of Adult Drug Misusers: Update (*2005) emphasised the usefulness of the tiered framework in helping to structure the provision of treatment for substance users, but acknowledged that the conceptual framework was not meant to be a rigid blueprint for provision[9]. It noted that the tiers refer to the level of the interventions provided and do not refer to the provider organisations. The four tiered structure of services outlined in *Models of Care* (2002) has similarities with other conceptual frameworks developed elsewhere in the world (see box 1, page 26). There is currently a national drive to improve the quality of Tier 4 treatment services as part of the wider NTA Treatment Effectiveness Strategy.

It is important to draw a distinction between "placement matching" and "modality matching". In placement matching, a service user is referred to a particular setting, such as intensive outpatient or residential care, while modality matching attempts to match a service user's needs to a specific treatment approach (such as motivational enhancement therapy), regardless of setting. When placement matching is disconnected from modality matching, treatment is likely to be less effective because it fails to respond to the individual needs of the service user[10]. Good treatment planning therefore combines modality matching (for all pertinent problems identified in the assessment) with placement matching (identifying the least intensive level of care that can safely and effectively provide the resources that will meet the service user's needs).

*Models of Care* (2002) emphasised the need for treatment to be assessment-driven and focused on the individual, using care planning as a key tool for implementation. Problems are identified and prioritised in the context of the service user's severity of illness and level of functioning. Treatment services should then be matched to the service user's needs over the period of care, with ongoing assessment of progress and treatment response influencing future treatment recommendations.

IPUs can be used for three broad groups of tasks – assessment, stabilisation and assisted withdrawal – and as such should be part of any integrated treatment system. The medically managed inpatient setting can deliver care-planned interventions to service users at any point in their treatment career, and availability should not be dependent on where an individual lives. When the focus of an IPU is only assisted withdrawal, many service users who could derive a health gain from such a service are excluded. Given the need for equal levels of access to all service modalities outlined in *Models of Care* (2002), a care plan developed in agencies providing either Tier 2 or Tier 3 interventions should utilise an IPU (or residential rehabilitation) if it is the most suitable place to achieve a particular goal efficiently and successfully.

In order to tailor an inpatient intervention to the service user's needs there should be flexibility around the length of admission. It is important for the service user, their family, the referring treatment agency and the IPU itself that an estimated length of admission is specified at the outset in accordance with the goals of the care plan. However, each individual will present with a unique combination of problems, and fixed upper limits to the length of stay are often unhelpful, particularly in complicated cases involving multiple substance use, chronic pain, pregnancy, or physical or psychiatric comorbidity.

**Box 1** **American Society for Addiction Medicine (ASAM) patient placement criteria: guiding principles**[10]

1. The goals of intervention and treatment determine the methods, intensity, frequency, and types of services provided
2. Treatment should be tailored to the individual and guided by an individualised treatment plan
3. There should be a choice of treatment levels – for clinical and financial reasons, the preferred level of care is the least intensive level that meets treatment objectives, while providing safety and security for the patient
4. A continuum of care must be available, with a seamless transfer between levels of care and philosophical congruence between providers of care
5. The patient's progress should be regularly assessed as they progress through the levels of care
6. The length of stay is determined by the patient's progress towards achieving his or her treatment plan goals and objectives. Fixed length of stay or program-driven treatment is not individualised to the patient's problems

*Five "levels of care" are defined (which have broad similarities with the tiers defined in Models of Care (2002)):*

0.5 Early intervention
1.0 Outpatient treatment
2.0 Intensive outpatient/partial hospitalisation
3.0 Residential/inpatient treatment
4.0 Medically managed intensive inpatient treatment

Level 3 maps almost directly onto Tier 4 in *Models of Care*, with one important and useful exception. The defining characteristic of all level 3 programs is that they serve individuals who need safe and stable living environments in order to develop their recovery skills. They can be said to be "medically monitored" in that a sufficient level of medical supervision can be provided by a visiting a general practitioner with some knowledge of the management of addiction problems. Such living environments may be housed in the same facility where treatment services are provided or they may be in a separate facility affiliated with the treatment provider. This would include residential rehabilitation services in the UK.

In contrast, level 4 services are explicitly defined as "medically managed". They provide a planned regimen of 24-hour medically directed evaluation, care, and treatment of mental and substance-related disorders in an acute care inpatient setting. They are staffed by designated addiction-credentialed physicians, including psychiatrists, as well as other mental health- and addiction-credentialed clinicians. Such services are delivered under a defined set of policies and procedures and have permanent facilities that include inpatient beds. Therefore, level 4 programs provide care to patients whose mental and substance-related problems are so severe that they require intensive multidisciplinary care. Treatment is provided 24 hours a day and the full resources of a general acute care hospital or psychiatric hospital are available. The treatment is specific to mental and substance-related disorders. However, the skills of the interdisciplinary team and the availability of support services allow the conjoint treatment of any co-occurring biomedical conditions that need to be addressed.

Research on the use of the ASAM PPC is on-going, but results suggest that use of even a rudimentary version of the criteria is associated with improved treatment retention[10].

### 1.4 Specialist and general settings

A recent national survey of IPUs has shown that there are twice as many services consisting of a few beds on a general psychiatric ward as stand alone specialist services[5]. The situation for inpatient alcohol treatment is less clear, but it is likely that this ratio is even higher.

When compared with specialist services, general ward-based services have:

- fewer beds per service
- lower bed occupancy
- shorter planned and actual admission periods
- a greater likelihood of being closed or unavailable
- less input from staff that specialise in the treatment of substance misuse problems
- less involvement of staff in admission procedures
- a narrower range of available medical and psychological treatment options

Furthermore, there is some evidence that using general services is not the most effective use of resources. Heroin addicts randomised to either a specialist inpatient drug dependence unit (DDU) in London or a general (non-drug specialist) psychiatric ward achieved markedly different outcomes[11]. A total of 52 of the 69 service users (75 per cent) admitted to the DDU remained in treatment to at least their first drug-free day, compared with only 13 of the 30 service users (43 per cent) admitted to the general ward. The specialist setting was associated with greater acceptance of randomisation, entry into hospital treatment, completion of assisted withdrawal in hospital, and opioid-free status at both two-month and seven-month follow-up.

Therefore, this report starts with the assumption that dedicated specialist IPUs are the correct setting in which to deliver inpatient treatment to service users with severe alcohol or drug dependence.

# 2. The services that a good inpatient unit can provide

## 2.1 The key features of an inpatient unit

- An IPU provides care to service users with substance-related problems (medical, psychological or social) that are so severe that they require medical, psychiatric, and psychological care 24 hours a day, 7 days per week
- IPU treatment is based on a plan of care, developed prior to admission, and should encompass relevant preparatory work and a seamless transition to on-going treatment after discharge. Therefore, emergency admissions are unlikely to be appropriate, although a care plan may utilise an IPU to, for example, achieve a period of respite from severe physical or psychological problems or for urgent stabilisation as required in pregnancy
- The IPU is staffed by a multidisciplinary team with specialist knowledge of the management of addiction problems
- The treatment provided by an IPU is individually tailored, flexible, and makes use of a menu of pharmacological, psychological and social interventions, and is specific to mental and substance-related disorders
- The skills of the IPU multidisciplinary team and the availability of support services allow the conjoint treatment of any co-occurring biomedical conditions that need to be addressed
- The full resources of a general acute care hospital or psychiatric hospital are available to the IPU, either directly (on the same site) or indirectly (through consultant referral). This may include medical, surgical, antenatal, dental advice and care, dietary, or medicines management advice
- An IPU treatment programme incorporates activities beyond the medical or psychological treatment process (e.g. employment, housing, social activities), so facilitating social re-integration
- IPU treatment incorporates a set of policies and procedures that set boundaries on behaviour (e.g. non-prescribed drug use), while enabling service users to be treated in an empathic manner

## 2.2 The core work of an inpatient unit

### *2.2.1 Assessment*

#### Background

Individuals with drug and alcohol dependence present with a wide range of psychiatric, physical and social problems. The stigma associated with such problems often leads to barriers to accessing medical care, particularly for women, the elderly, individuals from black and minority groups, the homeless, and those with drug or alcohol-related brain damage. Substance misuse services aim to provide a comprehensive assessment of these needs and formulate a treatment care plan to tackle them. However, the nature of community services is such that a comprehensive assessment may be difficult to conduct, particularly when there are multiple problems (see cases A and G, pages 61/62). The IPU provides the facilities and the personnel to do this work. Furthermore, a care plan made in community services may identify an inpatient environment as the most suitable place to achieve a particular goal of treatment, particularly if there are a range of problems to be addressed. IPUs have several potential advantages over less intensive programmes. A hospital setting

permits a high level of medical observation, supervision and safety for service users needing more intensive forms of care. Such services are indicated for the treatment of service users with complex substance use disorders, particularly when combined with psychiatric or physical comorbidity.

### Assessment: recommendations for the model service

The model service requires environmental and staffing resources to provide:

*Assessment of substance use*

It is particularly important to estimate the level of dependence on a variety of substances in high-risk populations (e.g. pregnant women). Although the preferred setting for assessment of most problems is the community in which the person lives, there are times when this is not possible due to the number and complexity of problems facing an individual. Staff should be trained in the use of objective and subjective instruments for assessing the extent of substance use, and there should be access to a range of laboratory-based tests.

*Assessment of physical health*

In liaison with primary care, inpatient clinical staff should complete a physical health assessment during the admission process and subsequently as needed. This should include the physical health (medical) history, medication prescribed on admission, current physical health assessment, physical health examination, investigations and care plan. More specialist physical health assessments will be necessary for particular groups, including the elderly, pregnant women, and those with liver disease and blood borne virus infections.

Regular liaison with other acute medical services is likely to mean visits to other services during an inpatient admission. Such visits have implications for staffing levels, as many will require a member of staff to escort the service user. The provision of regular physical monitoring (e.g. blood pressure, temperature), chaperones for intimate physical examinations, and other physical interventions such as parenteral administration of thiamine are also likely to have implications for minimum staffing levels.

*Assessment of mental health*

Much of the literature on dual diagnosis of substance misuse and mental illness has focused on service users with severe and enduring mental health problems. However, the co-occurrence of substance misuse and mood, anxiety and personality disorders is very common. Dual diagnosis is not often addressed unless the service user is clearly psychotic, and it also becomes an issue in developing a suitable treatment plan for the post-discharge period. Service users may also present with learning disabilities, developmental disorders, disrupted education, or cognitive impairment secondary to drug and alcohol use. Such service users benefit from neuropsychological and living skills assessment to guide the care planning process.

All inpatients should be assessed for the presence of comorbid psychological and psychiatric disorders, especially personality disorders, learning disabilities, mood disorders, and the presence of neuropsychological deficits. This should lead to the initiation of a treatment plan including:

- tailored psychological therapies
- coping skills training and educational strategies
- neuropsychological rehabilitation programmes
- appropriate pharmacotherapy where indicated
- occupational therapy (including training in activities of daily living)

The assessment will also influence the referral on to appropriate follow-up treatments available in the community (e.g. relapse prevention work, treatment for post-traumatic stress disorder or eating disorders). IPU treatment provides a window of opportunity to engage service users in treatment for comorbid psychological problems, and this may help to reduce associated morbidity and mortality. Individuals with substance use disorders are unlikely to gain the maximum benefit from ongoing treatment unless these comorbid disorders are addressed. The severity of comorbid psychiatric disorders has been shown to be the best predictor of outcome for service users enrolled in alcohol and drug treatment programmes[12].

Symptoms of anxiety and depression are prominent as part of the withdrawal syndrome, but usually subside between days 10 and 14. Individuals still experiencing significant discomfort with anxiety and depression at this point merit further assessment. If symptoms of anxiety and depression persist into weeks three and four then pharmacotherapy may be required, together with the appropriate psychological interventions.

### *2.2.2 Stabilisation*

#### Background

Many IPUs have become focused on assisted withdrawal by default, with a perceived focus on abstinence-based treatment goals. Although there is evidence that assisted withdrawal outcomes are better in an inpatient than a community setting[13], this advantage may be offset by economic considerations in cases of assisted withdrawal in stabilised, well motivated service users[14]. However, there is considerable evidence that the number of service users with more complex problems (co-existing physical and mental illness, dependence on more than one substance) is increasing. Such cases can be managed in a community setting, but specialist medically managed IPUs have potential advantages over less intensive community-based programmes. A hospital setting permits a high level of medical observation, supervision and safety for service users needing more intensive forms of care.

#### Stabilisation: recommendations for the model service

The IPU should have care pathways, clinical protocols, and sufficient human and physical resources to offer the following range of stabilisation procedures (see also section 3):

*Dose titration*

Induction with methadone presents a potential risk and should be undertaken with care. The risk of death during methadone induction has been calculated as nearly seven times greater than the risk of death prior to entering maintenance treatment. Service users with severe opioid dependence, or dependence on more than one substance, may benefit from dose titration conducted in an inpatient environment. Admission to an IPU with staff skilled in monitoring the effects of methadone and the opioid withdrawal syndrome may prevent the individual dropping out of treatment, or else continuing to supplement their methadone or buprenorphine dose with heroin. This may be particularly important in the case of a pregnant woman who is using opioid or stimulant drugs, as close observation of both mother and foetus can be ongoing throughout dose titration.

*Dose titration on injectable opioid medication*

Injectable opioid medications such as methadone and diamorphine are potentially available to service users

in the UK, and there is some evidence for their efficacy in certain service user groups. Admission to an IPU allows interventions to optimise the service user's injection technique and 24-hour monitoring allows safer and more efficient calculations of dosage. NTA guidelines (produced in 2003) for prescribing injectable opioid treatment recommend supervision of injecting, yet this is not always available in the community. Therefore IPUs can allow provision of a treatment that might otherwise not be provided.

*Stabilisation on maintenance therapy*

Community prescribing capacity has expanded enormously under the current drugs strategy. There is a strong evidence base for maintenance treatment with either methadone or buprenorphine, and doses have also increased in line with this evidence base. An important goal of maintenance treatment is cessation of all illicit opioid use, but some service users find this difficult to achieve. Use of heroin "on top" of a prescription of methadone can be problematic, and attempts to tackle it in the community may lead to increasing doses of methadone and rising opioid tolerance, without the desired break from the illicit drug market.

In many cases, a short (one or two week) admission to an IPU may be an effective way of breaking this cycle, particularly when followed up by day care or intensive community support. The aim of such an admission would be to stabilise the service user on an effective dose of either methadone or buprenorphine, partly by allowing a safe period where illicit drugs are not available and partly by facilitating assisted withdrawal from illicit opioids. The service user should also receive an intensive period of psychosocial work to equip them with skills necessary to help them remain free of illicit substances on discharge.

*Combination assisted withdrawal/stabilisation*

Many individuals on opioid maintenance therapy also use other substances such as crack cocaine or illicit benzodiazepines. Use of these other substances often prevents the user breaking free of the illicit drug market, making it harder to abstain from opioids. A period in an IPU may allow assessment and treatment of the withdrawal symptoms from stimulant drugs or benzodiazepines, and in doing so facilitate stabilisation on opioid maintenance treatment. This individual can then continue to receive Tier 3 interventions in a community setting.

About one third of service users on methadone treatment programmes consume excessive alcohol, thus increasing their risk of physical health problems. A proportion of these service users who have developed alcohol dependence need admission from time to time to withdraw from alcohol while they remain on methadone. IPUs treating this type of service user require considerable expertise in order to maximise treatment outcome and retention rates. This is particularly true if the situation is complicated by hepatitis B or C infection.

### *2.2.3 Assisted withdrawal*

#### Background

Assisted withdrawal is popular with users[15], possibly because some believe (generally incorrectly) that this is all they need to get off drugs or alcohol and remain substance-free. Others see assisted withdrawal as a way of obtaining short-term relief from their habit. It may also provide a period of respite from addictive drug use and its consequences, and the opportunity to engage with other types of treatment services[16]. This may be particularly true for users of stimulant drugs such as crack cocaine, where a period of assisted withdrawal may help to break a binge/collapse cycle. However, attempts to treat alcohol or drug addiction by means of assisted withdrawal alone have repeatedly been shown to have high rates of relapse to dependent use.

Assisted withdrawal should therefore be seen as the first step in a longer treatment process and needs to be integrated with relapse prevention or rehabilitation treatment programmes[14].

The likelihood of successful assisted withdrawal are increased where both service user and clinicians are in agreement about goals and procedures, including taking medication in prescribed amounts and schedules, and avoiding intervening use of the problem drug and other non-prescribed drugs. Withdrawal in an inpatient setting offers better opportunities for clinicians to ensure compliance with medication, and to manage complications. The process also offers a major opportunity to recruit service users into longer-term treatment to reduce the risk of relapse back into regular drug or alcohol use.

Randomised controlled withdrawal trials conducted in the addiction field have tended to show no difference between inpatient treatment and other modalities[17]. However, methodological issues with these studies hamper the interpretation of their results, as most exclude service users with serious medical, psychiatric or social comorbidity that might make random assignment to anything other than inpatient treatment hazardous. This has the effect of reducing any possible advantages that treatment in an inpatient setting may convey[18].

At present, inpatient assisted withdrawal is generally considered to be indicated for those individuals who have too many adverse prognostic features to be successful at withdrawal as an outpatient. However, uncontrolled studies have consistently shown that IPUs lead to higher rates of completion of the withdrawal process from opioids[14]. If it is true that an episode of assisted withdrawal is more likely to be successful in an IPU, then consideration should be given to admitting service users with less severe levels of dependence, particularly early in their drug/alcohol using careers. If this was linked to a clear pathway of care focused on maintaining abstinence it might be an effective (and cost effective) way of preventing long periods of maintenance treatment. Furthermore, there have been no structured studies of a mixed model of inpatient and outpatient assisted withdrawal, where treatment is commenced in the IPU but concluded in the community. This approach may benefit service users by combining the close supervision of initial inpatient withdrawal with an opportunity to have supported rehearsal of new coping skills in the community.

### Assisted withdrawal: recommendations for the model service

*Alcohol*

The majority of service users undergoing alcohol withdrawal can do so safely at home with regular supervision by their GP and a community team. However, the alcohol withdrawal syndrome is a significant medical condition which can be life threatening, particularly when it is associated with alcohol-related physical and psychiatric problems. A significant minority will require inpatient, medically managed alcohol withdrawal. Criteria for IPU treatment include:

- severe dependence
- a history of withdrawal complicated by delirium tremens or seizures
- poor physical health
- comorbid psychiatric conditions or a risk of suicide
- chaotic polydrug use
- lack of social support
- having no fixed abode
- a history of previous unsuccessful attempts at withdrawal in the community or as an inpatient

Alcohol withdrawal is associated with significant morbidity and mortality when improperly managed, with

up to 15 per cent of service users in alcohol withdrawal experiencing a withdrawal seizure. Benzodiazepines are recognised as the treatment of choice for alcohol withdrawal[19], with a flexible, individually-tailored approach usually adopted with regard to the number of days prescribing. Service users with a history of delirium tremens, head injury or cognitive impairment, may need longer withdrawal regimes (e.g. lasting 10 days or more).

All service users undergoing assisted withdrawal for severe alcohol dependence should be given intravenous or intramuscular thiamine in order to prevent Wernicke's encephalopathy. There are particular problems associated with offering adequate thiamine prophylaxis in community settings, including the safe administration of parenteral medication [20].

*Opioids*

There are four main pharmacological treatment strategies for managed opioid withdrawal, all of which have been subject to Cochrane Review:

1. Methadone
2. Alpha-2 adrenergic agonists (clonidine and lofexidine)
3. Buprenorphine
4. Rapid opioid withdrawal with opioid antagonists

Clinical efficacy is evaluated mainly in terms of rates of treatment completion and side effect profile. Overall the differences in outcome between the various methods are relatively minor, and it is therefore reasonable to offer the majority of service users a choice of treatment. There is marked individual variation in response and service users may have had favourable or difficult experiences with a particular treatment in the past and so have a clear view as to what suits them personally. It also enables the service user to participate in the treatment decision, improves their sense of self-efficacy and encourages active participation in the treatment process.

All IPUs should draw up protocols to guide the medicated treatment process and these protocols should be evidence-based where possible. However, it is recognised that treatment can be adjusted and modified in response to individual clinical needs. There is a particular need for such protocols when considering the pregnant service user, as the risks of withdrawal for the mother must be balanced against those for the foetus. Withdrawal generally needs to take place at a slower rate in this group, and should not happen in the first trimester and only with caution in the third.

*Stimulants*

Although the mainstay of treatment is currently psychological and psychosocial interventions targeted at retaining service users in treatment, admission to an IPU can serve four crucial aims:

1. to allow a break from cycles of heavy stimulant use and subsequent 'crashes'
2. to provide medicated relief of symptoms of cocaine withdrawal
3. to allow assessment of mental and physical state and appropriate medical treatment
4. to provide intensive psychosocial intervention to begin to equip the user with the skills to remain drug free

*Benzodiazepines*

Many opioid drug users presenting for treatment have a history of benzodiazepine use in the previous year and nearly half of opioid users in treatment have injected benzodiazepines. A 2003 survey of NHS community prescribing services estimated that the prevalence of benzodiazepine use was 40 per cent[21]. Untreated benzodiazepine withdrawal may precipitate psychosis, confusional states, and seizures. The treatment of benzodiazepine withdrawal in IPUs is invariably in the context of polydrug dependence, and may be undertaken concurrently with managed opioid withdrawal, although service users may experience more severe opioid withdrawal symptoms[22]. It also commonly occurs in service users using benzodiazepines in combination with heavy alcohol use. In such cases the two substances need a combined withdrawal process and a more intense or prolonged approach to withdrawal.

*Polydrug use*

The concurrent use of more than one type of drug is an increasingly common clinical problem, and drug users seeking treatment often present with dependence upon several drugs. In a national study of drug dependent service users in the UK services, about two thirds were found to be current users of three or more substances during the period prior to admission to treatment, and more than a third were using stimulants on a frequent basis [23]. The most common combinations that require clinical management during withdrawal involve two or more of the opioids, benzodiazepines, alcohol or stimulants.

Assisted withdrawal from two or more substances in combination is usually best managed in a hospital setting because of the risks of complex drug and withdrawal interactions, and the possible need for re-evaluation and adjustment of medication regimens[2]. Assisted withdrawal from one or more drugs may be required before a full assessment can be made of the primary problem drug. At present there is pressure on service users with polydrug dependence to achieve abstinence within the constraints of fixed length treatment programmes. IPUs should therefore have the capacity to offer variable lengths of stay, which would permit more flexibility in treatment of polydrug dependence and may improve outcome.

*Other drugs*

The misuse of psychoactive drugs is a constantly evolving phenomenon, with new substances of misuser appearing at a steady rate. The last 20 years have seen the emergence of ecstasy, GHB (often known as GBH) and ketamine to name but a few. The use of new and varying drugs presents a challenge to treatment services, particularly when intoxication or withdrawal of such substances causes severe physical and mental symptoms. IPUs have a crucial role in the management of withdrawal for such service users, and should have flexible assessment and treatment procedures to accommodate them.

## 2.3 Other important functions

### *2.3.1 Psychological interventions*

#### Background

Any form of psychological treatment for service users misusing psychoactive substances leads to better treatment outcomes when compared with no psychological treatment[24]. Strategies based on psychological

models of addiction play a crucial part in all stages of a treatment pathway, including engagement, assessment, maintenance, assisted withdrawal, and prevention of relapse. In order to achieve optimum efficacy, IPUs need to integrate psychological interventions into all aspects of their work.

A range of types of psychological intervention have been described[24], including:

- motivational enhancement therapy
- cognitive behavioural therapy
- coping skills training
- relapse prevention
- community reinforcement
- contingency management
- counselling/supportive-expressive psychotherapy
- family therapy
- social behaviour and network therapy
- 12-step facilitation therapy

### Psychological treatment models

Psychological treatment models have much to offer all three key roles of the IPU:

*Assessment*

Active assessment styles such as motivational interviewing elicit information while helping to improve motivation towards treatment. Functional analysis of problems and goal setting form a key part of care plan development. Cognitive assessment may be crucial in identifying learning disabilities and developmental disorders in cases of cognitive impairment secondary to alcohol or other drug use, and in assessing psychological factors maintaining substance misuse. Psychometric testing may also be an important part of the outcome evaluation and monitoring process.

*Stabilisation and assisted withdrawal*

Psychological and psychosocial interventions help to build motivation to achieve a goal, and to develop relapse management plans. Psychological therapies may also be used to treat underlying problems maintaining substance misuse.

*Psychological interventions: recommendations for the model service*

A mix of cognitive and behaviourally driven approaches may be best, and all psychological therapy should be individually tailored. Groups are effective and may provide benefits in terms of peer support, but are not suited to everyone.

Best practice needs consideration of:

- staffing – sufficient numbers of staff competent in psychological therapy to develop individual management plans and deliver them
- on-going supervision of staff to ensure fidelity to the approach

- training – staff need to have the skills to plan and deliver psychological interventions
- environment – there is a need for quiet, adequately sized rooms for delivering psychological interventions.
- evaluation of the efficacy of psychological interventions

### *2.3.2 Other activities*

#### Background

In order to deliver a comprehensive care package, medical and psychological approaches should be supplemented by occupational and "social" interventions.

Alcohol and drug dependence can occupy the majority of a person's time, either in obtaining the substance, using it, or experiencing the effects of it. This is likely to have led to a reduction in other activities in the person's life, including both work and leisure activities. Furthermore, alcohol or drug use may have led to a reduced level of social contact with others except in the context of substance use. It is also possible that heavy substance use started as a way of coping with anxiety or other difficulties in social relationships, or that a pattern of use developed before the individual had developed practical skills such as managing a budget, shopping, cooking or other activities of daily living.

Individuals with problems at a level that requires an IPU admission are likely to also be experiencing difficulties in housing, work, and relationships. Planned activities on the IPU can be an excellent way of assessing these deficits and developing a plan of intervention. Furthermore, boredom is a major risk factor for relapse back to problematic patterns of alcohol or drug use, and so it must be addressed while the person is resident in the IPU. Providing opportunities for mental and physical activity not only distract the individual from unpleasant withdrawal or other symptoms, but they can also be used as a way of teaching new skills that can be used after the IPU admission is over.

#### Other activities: recommendations for the model service

- The development of a comprehensive care package requires attention to service users' needs for education or training, housing and employment. The IPU must therefore have access to experts in these areas (such as social workers and occupational therapists) to provide assessment and recommendations for action

- The IPU should provide planned social and leisure activities – these should be arranged in such a way as to prevent long periods of inactivity and boredom, allow the development of positive social skills, and an increase in the service user's range of pleasant activities that don't involve drug or alcohol use

- Due to the pressure on nursing staff to deliver medical and psychological interventions, there is a need for an occupational therapist or an activity coordinator to oversee the above programme

- Physical activity should also be considered, and access to a gym under supervision allows the relief of tension and positive physical benefits

- Complementary interventions such as acupuncture and aromatherapy may also be useful adjuncts to medical and psychological interventions

### *2.3.3 Harm reduction issues*

#### Background

A period of IPU treatment means contact with the service user for 24 hours a day, seven days a week, and as such provides a valuable opportunity to deliver a range of interventions aimed at reducing harm.

In addition to the physical screening examination described above, consideration should be given to:

- testing for HIV, hepatitis B and C
- hepatitis B vaccination
- training in drug overdose prevention
- prevention of Wernicke-Korsakoff syndrome
- healthy lifestyle advice and smoking cessation interventions
- access to dental assessment and treatment

#### Harm reduction issues: recommendations for the model service

- *Testing for and vaccination against blood borne viruses*

  Most IPUs do not currently provide this service because of the short duration of stay and problems with staff training and follow-up. This often leads to a valuable opportunity to improve personal and public health being missed.

  Testing for hepatitis B, C and HIV, and hepatitis B vaccination should be provided for any at risk service user during an inpatient stay. It may be provided by a dedicated service linked to the IPU, or if this is not available, by the unit staff themselves. The former may allow easier follow-up of the service user in the community. The latter requires consideration of equipment, environment, clinical protocols, staff training and follow-up issues.

  There should also be close liaison with specialist services for the management of liver disease to allow the optimisation of treatment of blood borne virus-related or other liver problems during admission.

- *Training in drug overdose prevention*

  Among service users who have undergone assisted withdrawal in inpatient or residential services, an initial lapse to opioid use often occurs very soon after leaving the programme[25]. Although this initial lapse does not necessarily lead to a full relapse to daily use, the reduction or loss of tolerance that occurs during and subsequent to assisted withdrawal puts the individual at risk of a drug overdose if opioid use is resumed. Drug overdose continues to be one of the most frequent causes of death among drug misusers, and increased rates of fatal overdose have been reported among recently abstinent opioid addicts[26]. IPUs must be aware of the potential risks of overdose among service users who have been successfully withdrawn from opioids and who have lost their tolerance to the effects of opioids.

  Many opioid overdose deaths could be prevented by increasing overdose awareness and the provision of take-home emergency supplies of naloxone[27]. Recent research among opioid users has found strong levels of endorsement and a high willingness to undertake training and to apply emergency interventions

if needed[28,29]. A take-home supply of naloxone is now being prescribed by some drug treatment services to selected service users and their families, to prevent death while awaiting emergency services[30]

- Training covering overdose information, risky situations, recognising an opioid overdose, and the delivery of basic life support techniques should be given to all service users undergoing an assisted opioid withdrawal programme

- Consideration should also be given to prescribing naloxone to opioid dependent service users in conjunction with the relevant training

*Prevention of Wernicke-Korsakoff syndrome*

Most service users admitted to an IPU for medical management of alcohol withdrawal are at high risk of developing the Wernicke-Korsakoff syndrome. If managed inappropriately, this carries a mortality rate of over 15 per cent and results in permanent brain damage (Korsakoff's psychosis) in 85 per cent of survivors. IPUs must therefore be equipped to provide prophylaxis and treatment for this condition. Oral thiamine is ineffective in this condition. Therefore, appropriate facilities for parenteral thiamine treatment are necessary, including facilities to manage the rare cases of anaphylaxis that can result from this treatment.

*Healthy lifestyle advice and smoking cessation interventions*

Promoting a healthy lifestyle is integral to the work of a substance misuse service. This requires discussion with the service user about their daily living habits and motivation and desire to change them. The *Choosing Health* series published by the DH discusses the importance of making healthy choices regarding diet, the importance of activity and exercise and how to make those options easier for people to make (www.dh.gov.uk). The IPU must provide a range of nutritious food, and access to a specialist dietician service is important in planning for the specific dietary needs of the inpatient population.

Smoking is the single greatest cause of preventable illness and premature death in the UK. Effective treatment strategies are now available and should be offered to all smokers.

*Access to dental assessment and treatment*

Dental problems are common among heavy drug and alcohol-using populations, and access to NHS dentistry services has been reduced nationally. Therefore access to specialist dental care during an inpatient stay may be an extremely beneficial harm reduction measure.

### *2.3.4 Relapse prevention work*

#### Background

Service users who undergo assisted withdrawal, either on its own or as part of a stabilisation plan, are at high risk of relapse on discharge from the unit. The process of assisted withdrawal should not be expected to lead to the psychological and behavioural changes that provide a secure foundation for sustained abstinence. There remains a further need to tackle the problems of psychological dependence, which can

lead to relapse after assisted withdrawal, and even after prolonged periods of drug-free functioning.

### Relapse prevention work: recommendations for the model service

- Naltrexone may be useful for some opioid dependent service users, particularly if they have a strong personal motivation to use it, have a supportive family member, are employed and have a short opioid using history
- Disulfiram, acamprosate and naltrexone may all prove beneficial in reducing the risk of relapse to heavy alcohol consumption after a period of assisted withdrawal
- Relapse prevention training uses a variety of behavioural and cognitive strategies to identify high-risk situations for return to alcohol or drug use and to equip the user with the skills to reduce the risk of relapse
- It is useful to form links with Alcoholics Anonymous (AA) or Narcotics Anonymous (NA) groups, as AA or NA attendance may form part of a treatment care plan post-discharge or else part of an aftercare package. Facilitating AA and NA groups to meet on the IPU premises is one way of doing this. Twelve step facilitation in which engagement with AA is encouraged, also has proven efficacy in treating alcohol dependence.

# 3. Delivery issues

## 3.1 The interface with other parts of the treatment system

### *3.1.1 Preparation for admission*

#### Introduction

User, carer and clinical perspectives all suggest that the inpatient environment can play a crucial role in facilitating the delivery of some components of a comprehensive plan of care[31]. However, in order to optimise the utility of the IPU, and to bring it fully into the treatment care pathway, far more attention needs to be paid to pre-admission work. At present, many IPUs are driven by the conflicting priorities of their referring agencies. Although admission criteria can be set, these carry little weight in a system where care is passed on to a Tier 4 service without an over-arching care plan. Unrealistic goals may be set by community services with differing philosophies of care, and service users may also set themselves goals that are hard to reach as they feel they have no other therapeutic option.

Attempts at tackling these problems have been unrewarding. Many service users are admitted bewildered and ill-prepared for abstinence-based IPU treatment, with a history of erratic engagement with community services. Research evidence suggests that opioid dependent service users who have been pre-treated with methadone, are in regular contact with a counsellor, and have plans for abstinence based treatment after leaving hospital are more likely to succeed[32], while service users with very severe opioid dependence may do less well[33,34]. Polydrug dependence may also reduce the chance of successful withdrawal[35].

Service users who are admitted and leave within 48 hours reflect a lack of preparation and understanding of the treatment process; this is demoralising and destabilising, both for the service user, other service users on the ward, and staff. It is therefore important to integrate pre-admission preparation into the treatment process. There must be an emphasis on the development of integrated care pathways into (and out of) IPUs, with an emphasis on formal relationships, joint working and joint protocols between referral sources and the IPU. Such an approach also requires a review of current waiting times for IPU treatment, with consideration given to recognising the value of preparation time as part of the intervention.

#### Preparation for admission: recommendations for the model service

Key considerations for the pre-admission process are as follows:

- An information pack describing the unit and the treatment processes offered must be developed and distributed to all potential service users. The use of information technology may also facilitate this process, with one UK service offering a web-based 'virtual tour' of the IPU
- Liaison with referring agencies to discuss admission, establish clear goals of the admission and approximate likely duration. This must involve the service user (and their carers) as fully as possible
- An initial assessment done prior to admission by a member of the IPU. This is crucial in establishing the purpose and the goals of the inpatient admission within the context of a care plan developed in the community. Such an assessment should also be done within 4 weeks of the admission date, as the service user's situation is likely to alter fairly quickly. Physical examination and blood tests done prior to admission allow the planning of suitable interventions

- By viewing the period of IPU treatment as just one part of an overall care plan, post-discharge arrangements will naturally be considered prior to admission. Community-based services must be ready to take up a service user's care immediately upon discharge in order to maximise any gains achieved. For service users undertaking assisted withdrawal, consideration should be given to the need for day care or residential rehabilitation that follows seamlessly from the inpatient admission. In most cases this requires advance planning of funding, travel and other issues, which should be built into a plan of care. However, many service users undertaking assisted withdrawal from substances such as alcohol find it difficult to fully consider a long-term treatment plan prior to stopping substance use, and so flexibility needs to be built into the system

- An initial pre-admission visit to the IPU to see the environment and meet the staff can reduce anxiety in the service user and increase the likelihood of engagement

- Pre-admission education and counselling work is essential to optimise potential benefits from the period of inpatient admission

### Configuring the IPU for pre-admission best practice

These goals are easy to lay down, but less easy to deliver in practice. There is no one set way of achieving them, and the size and geography of the catchment area that the IPU serves will determine the ultimate configuration. Potential options include:

- *Configuration A*

  This involves devoting some of the resource of the IPU to an intermediate step between community services and inpatient admission. This may be set up as a form of day service where service users attend for between one day and three weeks for intensive assessment, physical examination and investigation, and preparatory information and counselling sessions. Ideally this is provided by a multi-disciplinary team, including user and carer representatives. Staff from the referring agencies should also be involved in the process. Integrating assessment for rehabilitation funding into this process also streamlines post-discharge treatment planning. The length of the pre-admission period would depend on the proposed goal of the inpatient admission (shorter for assessment work, longer for assisted withdrawal), and the nature of the substance used (shorter for alcohol dependence, longer for service users already receiving maintenance prescribing in the community).

  This configuration works best in a setting where one IPU serves a geographical area that is in easy contact with the unit by public transport. If service users are required to attend on a day care basis, long periods of travel each day are likely to be problematic.

- *Configuration B*

  In areas where geography dictates that service users have large distances to travel to an IPU, it is possible to commission staff based in community services to provide similar functions to those in configuration A. Pre-admission assessment and counselling work can be done within the base of the referring agency, with a short visit to the IPU prior to admission. Such an arrangement will ensure greater involvement in the process from the referring agency, but will also require attention to issues such as transport to the IPU. However, care would need to be taken to ensure that such an approach does not detract from community services. New funding would be needed to develop pre-admission worker posts, and they would need careful management to ensure that the system did not become overly focused on the IPU.

Whatever the preferred local configuration of services, it is useful to give one senior clinical member of the inpatient team the task of co-ordinating and overseeing the process of admission from the unit.

### *3.1.2 Linking inpatient units with post-discharge care*

#### Introduction

A second potential barrier to optimal use of IPUs is the link to on-going treatment post-discharge. There is a danger that the information obtained or the treatment gains made during admission can be lost if they are not followed-up immediately upon discharge. If the time spent in the IPU is seen as a means to achieve one part of a long-term, needs-based treatment plan, this is less likely to occur. Exit care packages are likely to involve multiple agencies and need careful advance planning. The system must be flexible, as the service user's goals often change as symptoms of substance withdrawal, physical, or mental illness are brought under control.

#### Assessment and stabilisation

By definition, assessment work aims to answer questions about the service user's difficulties and needs. The IPU should be working towards care-planning tasks developed by a community agency, with the understanding that they will return to the care of that agency with these issues addressed and a refined and enhanced care plan.

Service users discharged following a period of stabilisation may also return to the Tier 3 service that referred them, but may need access to a range of day care provision to help maintain the benefits accrued during the inpatient stay. This set of services would not be abstinence-based, but would need the capacity to support the maintenance of abstinence from particular substances (e.g. a service providing opioid maintenance may need to support a service user who is abstinent from alcohol following an assisted withdrawal process in an IPU).

#### Assisted withdrawal

Assisted withdrawal is rarely effective in the long-term as a stand alone treatment for drug dependence. Significantly better treatment outcome has been observed among service users who completed assisted withdrawal and went on to spend at least six weeks in a recovery and/or residential rehabilitation unit. In contrast, there were no significant differences between those who didn't complete assisted withdrawal and those who did but had no post-discharge care on the majority of measures of drug use during follow-up[34].

Service users discharged following assisted withdrawal should either go to residential rehabilitation or should be able to access abstinence-based treatment locally. Post-withdrawal services need to have access to a complete range of interventions, including medical, psychiatric, psychological, education, training, access to volunteering, access to work, and help with housing. Models that provide only part of this range of needs will not optimise the potential for these service users.

There has been some progress in recent years in the provision of post-discharge care teams and day programmes. An example of good practice is Salford where the day care service has many positive

characteristics usually associated with non-statutory services, but is part of the addiction directorate of a mental health trust and thus has access to the full range of expertise available from statutory services.

### Linking inpatient units with post-discharge care: recommendations for the model service

- A choice of post-discharge care packages should be available to allow individually tailored treatment according to care-planned need. Provision needs to include both abstinence and non-abstinence based settings and will be different for service users accessing the different pathways within the IPU (i.e. assessment, stabilisation, assisted withdrawal)

- Despite the remit for referrers to be actively involved, before during and after an inpatient admission, there is also a role for staff attached to the IPU to facilitate the continuity of care. The precise arrangements will vary according to local characteristics, including geography and number of referrers. Units serving a large number of referrers will need more resource for pre- and post-treatment liaison. Examples of good practice should be promoted, such as joint clinical meetings for community and IPUs to ensure an inpatient episode is a component of through care and treatment

- IPUs need more flexibility to support service users in achieving their treatment goals. For example, the provision of support workers within the unit would enable service users to be accompanied to appointments about their mental and physical health issues, to post-discharge treatment facilities, as well as to community team appointments

- The length of treatment should be determined by service user need, with the possibility of longer stays where indicated (e.g. in pregnancy). While there should be an agreed likely duration of stay, when this changes during the admission flexibility should be expected by referrers, inpatient providers and commissioners

- The effect of the above changes on the current waiting time targets will need to be reviewed

- Where a service user's treatment plan includes pharmacological agonist treatment, this should be commenced before discharge. The post-discharge treatment services must have seamless provision for continued monitoring and provision of this treatment by an addiction specialist

- More work should be done to involve the service user's family and wider social network in their IPU treatment plan, with a view to developing social networks to support post-discharge treatment goals[36]

- Further research should be conducted into the optimum configuration of the interface between inpatient and post-discharge treatment. There is evidence that seamless progress from the assisted withdrawal phase of treatment into a rehabilitation centre on the same site can improve outcomes[34]. The establishment of assisted withdrawal facilities by some UK rehabilitation centres therefore seems an appropriate development for service users with uncomplicated histories who are well motivated. The establishment of larger centres combining a full IPU and a rehabilitation centre may be an appropriate strategy in some parts of the UK (e.g. for services covering a large geographical area)

- A strategy covering both IPU and residential rehabilitation provision should be considered for each region

## 3.2 The service user and carer perspective

### *3.2.1 Background*

The value of the contribution of the views of service users and carers to the delivery of treatment services has been increasingly recognised over the last few years. Under the *NHS Plan* (2000) and the *Health and Social Care Bill* (2001) there is now a statutory duty to involve and consult service users, carers and the general public regarding the planning and provision of services, proposals for changes in service provision and decisions to be made affecting service delivery. The aim of the *NHS Plan* is to change the existing culture and embed service user and public opinion at the core of service delivery.

The National Patient Survey Programme was introduced by the DH in 2001. All mental health trusts were surveyed by the Healthcare Commission in 2004/05, seeking service user views on quality of interpersonal contact with healthcare workers (including being listened to and treated with respect and dignity), accessibility of healthcare workers and explanation of users' condition, treatment and side effects. They were also asked for their opinion on the opportunity available to express their views and have a say in decisions about their treatment and care. In general the results indicated that there was substantial room for improvement. This can only be achieved by strengthening collaborative structures with service users, including service users' forums and consultation policies. Treatment responsive to the needs of service users is more likely to impact favourably on treatment retention and outcome.

#### The service user and carer perspective: recommendations for the model service

- IPUs should engage actively with service users in planning, reviewing and delivering care
- Each service user should have been actively engaged in drawing up their care plan prior to the admission and in reviewing it during the admission
- IPUs should provide good quality information for service users about the unit, treatment pathways, policies, expectations (e.g. web-based 'virtual' tour of alcohol and drug IPUs at Bolton Salford and Trafford Trust)
- Service users should expect to have access to an IPU with the full range of facilities and should expect to have a comprehensive post-discharge plan. Many service users who have achieved abstinence have very low levels of expectation with regard to post-discharge care. IPUs should engage with them pro-actively to raise their level of awareness and expectation
- IPUs should facilitate service user support groups as part of their post-discharge care function
- IPUs should have procedures and policies to support ex-service user involvement as volunteers with routes into paid employment. Volunteer schemes need to be well managed with good governance arrangements (e.g. Wentworth House Service User Support Group in the North West has been established as an organisation with charitable status)
- IPUs should carry out regular service user satisfaction surveys and act on the results

## 3.3 Staffing

### *3.3.1 Background*

The recommendations contained elsewhere in this document represent the work of a model IPU working to maximum capacity. Such a service is totally dependent on a skilled and motivated multidisciplinary workforce. Current inpatient provision is characterised by an extremely varied workforce, reflecting a combination of:

- staff shortages
- limited recognition of the unique roles and experience of inpatient staff in terms of pay and career development
- the lack of a clear blueprint for IPUs

### Staffing: recommendations for the model service

The service should be staffed by a multi-disciplinary team with specialist training in the management of addictive behaviours. In NHS settings a specialist doctor at consultant level (responsible medical officer or RMO) will always provide clinical leadership to such a team, but management leadership may come from any professional group. The exact configuration of the clinical team will depend on:

- available financial resources
- the ability to recruit specialist professional staff
- the needs of the service user group served by the IPU
- the goals of treatment

### Optimal staffing for a 15-bedded unit

Specialist IPUs in England have a variety of staffing configurations (see box 2), but the following represents an optimal staffing for a 15-bedded unit.

*Medical*

- Consultant in addiction psychiatry*- 0.5 whole time equivalent (WTE) ( i.e. a full-time consultant providing half of their time to the IPU for clinical, teaching, research and administration matters)
- Staff grade/specialist registrar/senior house officer (SHO) in psychiatry† - likely to be several different doctors making up one WTE in total (i.e. a doctor present on the unit five days per week from nine to five)
- General practitioner/physician - 0.2 WTE (regular weekly clinic)
- Out of hours residential medical cover is provided by a SHO on an on-call rota, with non-resident consultant support

*or other Substance Misuse Specialist (as defined by the document 'Roles and Responsibilities of Doctors in the Provision of Treatment for Drug and Alcohol Misusers[37]

† With changes in the medical careers structure and the introduction of the European Working Time Directive, junior doctors in training grades (Senior House Officers or Specialist Registrars) can no longer provide the level or continuity of service provision that is required to adequately staff IPUs. The role of a Staff Grade or Associate Specialist doctor is therefore becoming increasingly important. However, training grade staff should still be involved in IPUs in order to gain experience in the management of complex cases in an inpatient setting

*Psychology*

- Clinical psychologist (band 8C) – 0.5 WTE
- Assistant psychologist (band 5) – 1 WTE
- Psychosocial programme co-ordinator – 1 WTE
- Social worker – 0.5 WTE
- Ward manager (band 7 nurse) – 1 WTE

*Nursing*

- A mix of grades from Agenda for Change band 5 to 6
- A mix of nurses from mental health and general nursing backgrounds can be useful
- Enough to staff two each shift (taking into account annual leave and study leave)

*Assistant practitioners (band 4) / Support workers (band 3)*

- Enough to staff four per shift
- Occupational therapist (OT) / Activities coordinator – 1 WTE
- Pharmacist – 0.5 WTE
- Senior management – 0.5 WTE
- Administration – 1.0 WTE

## Examples of staffing patterns in specialist units in England

**Box 2a**

*1. Service A*

- 14 beds for primary alcohol and primary drug problems
- Serves a total urban population of 2.4 million people

| | |
|---|---|
| Medical | Consultant in addiction psychiatry – 0.2 WTE<br>Clinical assistant – 0.4 WTE<br>Senior house officer in psychiatry – 0.7 WTE |
| Psychology | Clinical psychologist – 0.2 WTE<br>Assistant psychologist – 0.4 WTE |
| Nursing | Modern matron – 0.3 WTE<br>Team leader (band 7) – 1 WTE<br>Charge nurse (band 6) – 2 WTE<br>Senior staff nurse (band 5) – 5 WTE<br>Junior staff nurse (band 5) – 2 WTE<br><br>Drug and alcohol workers (band 3) – 4 WTE |
| Occupational therapy | OT – 1 WTE<br>OT students – 2 WTE |
| Volunteer | 1 WTE |

**Box 2b**

*2. Service B*

- 21 beds for primary drug problems
- Serves a total urban population of 2.4 million people

| | |
|---|---|
| Medical | Consultant in addiction psychiatry – 0.5 WTE<br>Specialist registrar in addiction psychiatry – 0.5 WTE<br>Staff grade in psychiatry – 0.8 WTE<br>Senior house officer in psychiatry – 0.5 WTE |
| Psychology | Clinical psychologist – 0.6 WTE<br>Assistant psychologist – 0.5 WTE |
| Nursing | Modern matron – 0.3 WTE<br>Team leader (band 7) – 1 WTE<br>Charge nurse (band 6) – 3 WTE<br>Staff nurse – 12 WTE<br><br>Drug and alcohol workers (band 3) – 6 WTE |
| Occupational therapy | OT (band 6) – 0.6 WTE<br>OT (band 5) – 1 WTE<br>OT technician – 1 WTE |
| Administration | Senior administrator – 1 WTE<br>Ward clerk – 1 WTE<br>Secretary – 0.5 WTE |

+ phlebotomy 1 visit per week
+ pharmacy and pathology services from main hospital

**Box 2c**

*3. Service C*

- Six beds on specialist ward for primary alcohol and drug problems
- Serves a large, mainly rural area with three towns and a total population of 560,000 people

| | |
|---|---|
| Medical | Consultant in addiction psychiatry – 0.2 WTE<br>Staff grade in psychiatry – 0.2 WTE<br>Senior clinical medical officer – 0.4 WTE<br>Senior house officer – 0.3 WTE (when in post – approximately 6 months per year) |
| Nursing | Ward manager – 1 WTE<br>Deputy ward manager – 1 WTE<br>Staff nurses – 5.3 WTE<br>BBV specialist nurse – 0.1 WTE |
| Health care assistants | 6 WTE |
| Physiotherapist | 0.3 WTE |
| Sports therapy | 0.4 WTE |
| Administration | Admin worker – 0.3 WTE |
| Senior management | 0.1 WTE |

**Box 2d**

*4. Service D*

- 20 beds for primary drug problems
- Serves a mainly urban conurbation of 4.5 million people

| | |
|---|---|
| Medical | Consultant in addiction psychiatry – 1 WTE<br>Senior house officer – 2 WTE |
| Nursing | Nurse consultant – 0.5 WTE<br>Advanced nurse practitioner – 0.5 WTE<br>Matron – 1 WTE<br>Ward manager – 1 WTE<br>Staff nurses – 10 WTE |

Support workers - 7 WTE
Group therapy co-ordinator – 1 WTE
Physiotherapist – 0.2 WTE

| | |
|---|---|
| Administration | Admin worker – 1 WTE |
| Pre-admission work | Clinical nurse specialist – 1 WTE<br>Senior administrator – 0.5 WTE<br>Administrator – 1 WTE |

Senior management – 0.3 WTE

**Box 2e**

*5. Service E*

- 15 beds for primary alcohol problems
- Serves an urban population of 4.5 million people

| | |
|---|---|
| Medical | Consultant in addiction psychiatry – 1 WTE (2 x 0.5 WTE)<br>Staff grade in addiction psychiatry – 0.5 WTE<br>Senior house officer – 1 WTE |
| Nursing | Nurse consultant – 0.5 WTE<br>Advanced nurse practitioner – 0.5 WTE<br>Matron – 1 WTE<br>Ward manager – 1 WTE<br>Qualified nursing staff – 8 WTE |

Support workers – 7 WTE

Administration worker – 0.5 WTE

| | |
|---|---|
| Pre-admission work | Clinical nurse specialist – 0.6 WTE<br>Senior administrator – 0.5 WTE<br>Administrator – 1 WTE |

Senior management – 0.5 WTE

**Box 2f**

*6. Service F*

- 7 beds for primary alcohol and primary drug problems
- Serves a mixed urban and rural area of 300,000 people

| | |
|---|---|
| Medical | Consultant in addiction psychiatry – 0.2 WTE<br>Staff grade in psychiatry – 0.4 WTE<br>Senior house officer – 0.35 WTE |
| Nursing | Team leader – 1 WTE<br>Charge nurses – 2 WTE<br>Staff nurses – 6.5 WTE<br>BBV specialist nurse – 0.1 WTE |

Senior support workers – 2.8 WTE
Support workers – 7 WTE

Administration – 1 WTE

Senior Management – 0.5 WTE

+ Pharmacy services from main hospital

## 3.4 Training

### *3.4.1 Background*

Despite the high levels of clinical skill needed, there are no agreed training requirements or recommended educational pathways for staff working in IPUs across England. Each individual professional group has its own qualification criteria for substance misuse careers, but there is no recognition of the special skills required for working in an IPU and no way that commissioners can judge the quality of a service through its staffing. New clinical governance requirements, staff pay bandings and models of care give services the opportunity to make working in an IPU more attractive, and to raise its profile to that of equivalent community services.

#### Training: recommendations for the model service

- Training should build on Drug and Alcohol National Occupational Standards (DANOS) principles to develop specific competencies for specialist IPU staff
- Each IPU should have an in-house training programme covering all aspects of assessment, stabilisation and assisted withdrawal technology, psychological interventions, physical health issues, and the management of special populations such as pregnant women
- In order to tackle problems with recruitment and retention of inpatient staff, consideration should be given to apprenticeship and rotational training schemes for junior staff that incorporate inpatient

experience. Staff rotation between inpatient and community services would be particularly advantageous from the perspective of both training and service provision

- Each unit should have written clinical protocols, a unit handbook and an operational manual
- Each unit should maintain a small in-house reference library for training purposes, and have access to multi-media equipment
- There should be a clinical audit and research component to each unit training programme
- Service users and carers should be involved in in-house training where possible
- A regular, structured away day should be part of the annual training cycle
- Regular clinical supervision is essential for the delivery of evidence-based psychosocial interventions
- Staff appraisal must occur on a yearly basis, and include training needs

## 3.5 Environment

### *3.5.1 Background*

Historically little attention has been paid to the location and design of IPUs. We are now in a position to learn from over 40 years' experience of inpatient facilities as to what works best in terms of design, bed numbers and location for a model IPU. There is a role for the multidisciplinary team and service users and their carers in the design of IPUs.

#### Environment: recommendations for the model service

There may be advantages if:

- Beds for service users with primary alcohol and primary drug problems are separated i.e. on different wards of the unit
- Beds for assessment/stabilisation work and assisted withdrawal programmes are separated (i.e. on different wards of the unit)
  However, practical issues may prevent this arrangement, and local issues such as the size of the unit, its location, and its catchment area population will influence the exact arrangement. For example, pooling staff and other resources is often useful in smaller units.
- Ideally wards within IPUs should have no more than 15 beds (although the overall unit is often larger than this)

- Consideration should be given to providing female-only IPUs or female-only sections of mixed IPUs

- The population served by a 15-bedded IPU will depend on the local level of alcohol or drug problems, the level of community and other medical and services, and the degree of integration of local care pathways. However, a ratio of 15 beds (for both service users with primary alcohol and drug problems) per half a million total population is appropriate. This is in line with recommendations, made by the Royal College of Psychiatrists in 2002, of three beds for 100,000 total population, with a minimum of 12 beds to establish critical mass and a group ethos[38]

- It is possible to use data from each DAT and regional area to model the size of IPU required depending on the population of drug users served (see Appendix 2)

- Commissioning arrangements will vary depending on location:

  - Cities with a population of between 250,000 and one million people may be well suited to having a single standalone IPU, as it is likely to be in easy reach of most of the population
  - London and large conurbations will require several large units, each located to make access as easy as possible for the largest percentage of its in-need population
  - Large rural areas may need a hybrid approach. This could involve a number of smaller specialist wards within psychiatric or acute medical hospitals forming a wider regional network

### *3.5.2 Location and design*

- IPUs should be located near enough to allow for easy access to a general hospital for assessment and emergency medical care

- IPUs should be as spacious as possible, with outdoor space available

- Single rooms with a bathroom en suite are ideal

- All units should have:

  - well equipped clinical examination rooms
  - well equipped consulting rooms ensuring privacy
  - a supervised urine testing room
  - a dispensing room with a way of separating staff from service users during dispensing
  - a large group room
  - a room for family visits (including play equipment)
  - a designated staff room with personal lockers, shower and toilet facilities and an area for refreshments and private time

- The nursing station needs to be close to key clinical observational rooms for service users, with physical health problems or those suffering intense withdrawal symptoms

- All rooms should have safety alarms

- All clinical rooms should have IT connections

- All units must have wheelchair access
- There is a current move towards a smoke-free policy on hospital wards. IPUs should give due consideration to the pros and cons that implementing such a policy will bring. In reality there is likely to be a smoking room on the ward, but with a severely restricted capacity. This will limit the use of the smoking room as a social hub, but the likelihood is that the majority of service users will be addicted to nicotine. Therefore they must be informed of the ward's smoke free status at the point of referral, and smoking cessation input should be offered before admission. Nicotine replacement therapy should be offered to those who wish to stop smoking during their IPU stay

## 3.6 Special populations

### *3.6.1 Black and minority ethnic groups*

There is a trend towards increasing substance use in black and minority ethnic group populations and IPUs should be aware of the mix of ethnic and cultural groups present in the population that they serve. IPU staffing should reflect that of their target populations, and staff should have an understanding of relevant cultural issues. Community consultation should be part of IPU planning initiatives, and the IPU environment should respect different cultural beliefs and practices. For example, it is important for the IPU to provide a food menu that reflects religious and cultural preferences, and also allow some flexibility in treatment programmes to take into account the observation of religious practice.

### *3.6.2 Young people*

This report focuses on IPUs for adults, but acknowledges that young people have special needs that are not met by adult-orientated services. It is usually inappropriate to place a person under the age of 18 in a facility designed for older people, and so development of inpatient facilities for this group needs to be considered by the commissioning process in each area of the country.

### *3.6.3 Older adults*

As the population ages, addiction problems will become increasingly prevalent in older adult groups and IPUs will need to be aware of the needs of older service users. Many of these will overlap with those of service users with co-existing physical problems (see 3.6.5), but IPUs also need to tailor medical, psychological and social treatment packages to the needs of older people.

### *3.6.4 Pregnant women*

Pregnant women should be fast tracked into IPUs if they require assessment, stabilisation or assisted withdrawal. It is important to address the needs of both the mother and the foetus and IPUs allow for:

- accurate assessment

- accurate dose titration
- opportunities to address drug or alcohol use
- engagement with antenatal care services
- assisted withdrawal where appropriate

Research clearly identifies pregnancy as a "window of opportunity" for treatment, as the woman's motivation is increased by her wish not to harm her child. Within the NHS, however, specific provision is not available to meet the needs of pregnant women or those of the mother and newborn. Most IPUs are mixed gender, do not have provision for mothers and babies, and focus on time limited assisted withdrawal interventions that are not clinically recommended during pregnancy[19]. IPUs should have provision for pregnant women. Interventions shown to be effective in this group should be available. The IPU should allow for joint working with the woman's partner and/or family, in order to address social and psychological needs as well as the treatment of the woman herself.

### *3.6.5 Comorbidity of physical illness and substance misuse*

As highlighted throughout this document, physical comorbidity is a significant problem in drug and alcohol dependent populations. Service users may develop drug or alcohol dependence to cope with chronic physical problems, or may develop severe physical problems as a result of heavy substance use. Acute medical problems require management in a hospital setting, but substance misuse IPUs have a role in supporting acute services and primary care in assessing and managing physical comorbidity in this vulnerable group.

Alcohol or drug dependent service users may not receive adequate care from primary or secondary medical services due to a combination of:

- stigma
- lack of knowledge of addiction in the treating agency
- difficulties with service user engagement
- the sheer complexity of their problems

IPUs may offer valuable assessment or stabilisation of medical problems, and can work synergistically with acute medical services (e.g. the intravenous drug user who has a deep vein thrombosis diagnosed in an acute medical hospital, but completes his medical treatment in an IPU as part of a wider programme to tackle his drug use problems). IPUs should therefore have a high level of expertise in assessing and managing the comorbidity of physical illness and substance misuse, and be well equipped in terms of physical resources and environment.

### *3.6.6 Comorbidity of mental illness and substance misuse*

DH policy states that service users with severe and enduring mental illness and substance misuse should have their care primariy managed by mental health services[39]. However, IPUs have a role in supporting such services through the assessment and on-going management of the co-existing substance misuse problem. Furthermore, a majority of service users presenting to community substance misuse treatment services have other mental health problems, most commonly depression, anxiety or personality disorders. Such disorders may be difficult to assess and treat in a community setting, particularly if drugs or alcohol are used as a form of self-medication.

## 3.7 Policies and procedures

### *3.7.1 Background*

Part of what makes an IPU effective is a treatment mileu directed towards recovery. Therefore IPUs require clear and specific procedures in order to provide a safe and therapeutic environment. It is important that service users are well informed about the IPU's treatment programme, policies and procedures, and should be able to agree to them as a condition of admission. The unit policy should expect all service users to participate in the treatment programme except for those who are judged to be too unwell by unit staff. Admission will also require undertakings not to use illicit drugs or alcohol and to refrain from unacceptable behaviour. This will typically mean no actual or threatened violence, no racist or other discriminatory talk or behaviour. Service users will also be expected to refrain from behaviour that puts others at risk of relapse. The response of staff to service users who are not complying with the contract will typically be to point this out in the first instance and attempt to get a commitment to change, except in the case of behaviours which warrant discharge.

#### Policies and procedures: recommendations for the model service

##### Access to visitors

The role of visiting family and friends must take place within a context that ensures support and safety for the service user. Visitors during an inpatient stay can be both positive and negative. They can provide much needed support and encouragement or can be involved in conflict with the service user. Either way, there is the risk that they will bring illicit drugs or alcohol to a service user.

Units should have specific time for visitors in order that the therapeutic programme proceeds without interruption. Service users should be asked to identify suitable visitors at the beginning of their admission, focussing on those who are likely to help them achieve their treatment goal, and others should not be allowed to visit.

##### Use of illicit drugs, alcohol and tobacco

Use of illicit drugs or alcohol should usually lead to discharge. For many service users this will be consistent with their treatment aim of abstinence. However where a service user is admitted for stabilisation rather than assisted withdrawal they will need clear communication that for the duration of their stay they are committing to abstinence from all but prescribed medication. The use of alcohol may be a problem for service users who have not been admitted for assisted alcohol withdrawal, but have to remain abstinent during their stay. They may underestimate or minimise the effects of alcohol and seek it out during the admission, leading to early discharge. IPUs situated close to retail outlets for alcohol will need procedures for accompanied and unaccompanied visits to the shops at each stage of the admission.

For most drugs the service will be providing an effective substitution or assisted withdrawal regime. However, in the case of cannabis this is not possible, since the drugs that may be prescribed to relieve cannabis withdrawal symptoms are not particularly effective. Service users may underestimate the extent of cannabis dependence, then attempt to smoke it while on the ward once they have found it difficult to manage without. In their everyday lives, cannabis may not even be perceived as a problem drug due to easy

availability, but in the restricted environment of the IPU it can be so. Service users may know from prior experience that cannabis helps their opioid or stimulant withdrawal symptoms and so may try to augment their prescribed withdrawal regime. It is important for staff to raise the issue of cannabis use early in an admission and address the difficulties service users may have in order to minimise early discharge due to cannabis use.

The majority of problem drug or alcohol users are dependent on nicotine. It is unrealistic to expect abstinence from smoking, but to protect staff and to promote healthier lifestyles smoking should be restricted to designated areas only.

### Drug Testing

In order to maintain a drug and alcohol free environment, staff will be required to monitor the consumption of drugs or alcohol. Drug testing is part of this activity. Generally drug testing is perceived by service users as a negative aspect of the admission, although it should be possible to reframe it as part of the strategy that they and the unit can adopt to keep them safe, and to demonstrate good progress within treatment. Indeed, negative drug testing results may be useful for service users to show to family, friends, child care and other social agencies.

Drug testing should be part of the admission procedure in order to provide a baseline for each service user and to confirm the pre-admission history. Thereafter service users should be asked for drug testing samples on a random basis (typically 20 per cent of service users each day). Testing should become more frequent when staff have concerns about a particular individual's risk or likelihood of drug use, or about the unit in general. If staff have concerns about a service user using illicit drugs this will generally be fed back to the service user and part of this feedback process will be a request for a urine or oral fluid sample. If staff have concerns about the unit in general then they will discuss the increased frequency of sampling or the need to sample the whole unit in order to maintain the drug free environment. In this context service users will often elect to take their own discharge, thereby averting a compulsory discharge.

### Methods for drug testing include:

- *Laboratory urinalysis using immunoassay screening and GCMS*
  This is generally the "gold standard". Key issues are the time within which a result will be available, the local cost, and the need to supervise sample provision
- *Urine "dip-testing"*
  Various instant result kits are available that use immunoassay techniques. They tend to have a higher false positive rate than other techniques that are backed up with GCMS, which needs to be borne in mind when interpreting results
- *Oral mouth swabs*
  These are convenient and can give either instant (immunoassay) or within 48-hour results. They tend to be more costly, but may be useful in planning treatment

It is important to recognise the potential limitations of drug testing, and the need to develop protocols for the effective use of such tests in IPUs. Staff also require regular training to ensure that such protocols are implemented effectively.

### Unplanned discharge

This will take place when unit rules have been breached, usually by the use of illicit drugs or alcohol, by

actual or threatened violence or other persistently inappropriate behaviour.

Unplanned discharge is an event requiring a careful assessment of risk to the service user, staff and other service users. Following this assessment the service user may be:

- discharged with appropriate supportive arrangements made
- retained as an informal service user (with the breach of rules managed in a different way)
- assessed under the mental health act (rare)

If the service user is not fit for discharge due to their physical health, the breach of rules will need to be managed in a different way.

When a service user is being discharged the staff will take into account the time of day and vulnerability of the service user. This may mean that where a need for early discharge is identified at night, the discharge takes place early the next day.

Where a service user poses an immediate and serious risk to staff and other service users due to their behaviour discharge will be immediate, with support from security or local police as necessary. Where possible staff will put in place an alternative discharge plan and will inform community agencies (principally the referring agency) immediately.

### Police

While violence on addiction units is the exception rather than the rule, it is helpful to have agreed working arrangements with the local police service in order to access appropriate support when it is necessary. Often what is required is a low-key presence that gives a service user a clear message about the consequences of further threatening behaviour and allows the service user to leave peacefully.

### Readmission

It is useful to have local agreements with referrers about readmission, and these will be influenced by the capacity of the IPU and the availability of alternative treatments (i.e. community assisted withdrawal or stabilisation). Readmission can be viewed negatively, allowing the service user to reduce their sense of personal responsibility for an unsuccessful admission, but on the other hand, a readmission may fit well with a view of relapse prevention as a learning process. When a service user has lapsed during an admission, it may be particularly effective to plan a readmission to capitalise on the learning from this lapse.

While there should be local agreements, readmissions will typically require individual case assessment, since the circumstances of previous treatment and of lapse are relevant. Factors to consider include:

- number of previous admissions
- time since last admission
- change in circumstances
- evidence of commitment to treatment goals
- severity of problems (physical health, mental health, dependence, criminal justice, child care)
- whether previous discharge was planned or unplanned

Planned readmission can be very powerful, especially where a service user presents with an unrealistic

treatment goal or changes their treatment goal during admission. For example:

- a service user who wants assisted withdrawal, but is not suitable in terms of illicit drug use and social situation may be treated initially with stabilisation and given a target of readmission to aim at (e.g. within 6 months)
- a service user who has an unrealistic wish of assisted withdrawal during pregnancy may be guided towards stabilisation or partial withdrawal, followed by a planned readmission when the baby has been born

### Child protection

IPUs should have policies to guide visits by children to the unit. These should be drawn up in partnership with local child protection services and a social worker with child protection experience should be part of the team. Issues will arise in terms of children visiting and concerns about suitable arrangements at home during the admission, especially if the treatment plan changes or is not completed as planned.

### Ex-users as staff

Staff who have been previous service users of substance misuse services can be an extremely valuable section of the workforce and are often employed on IPUs in support worker roles. IPUs need clear policies governing the employment of such staff, in order to maximise their potential contribution to the workforce and to reduce the risks of relapse or other problems arising as a consequence of their previous experiences.

### Volunteers

The contribution made by volunteers can also be very useful in this setting. Volunteering may be a step towards paid employment for those who are ex-service users and aim for employment in the sector, or for others aiming to work in this field but who need clinical experience. Policies for the use of volunteers should be drawn up to maximise their potential contribution to the workforce and to reduce the risks presented by their lack of experience.

## 3.8 Quality assurance

### *3.8.1 Background*

Since April 2005 the NHS has had a new performance framework driven by *Standards for Better Health*[1], which set out the level of quality all organisations providing NHS care are expected to meet or aspire to. *Standards for Better Health* also forms a key part of the performance assessment by the Healthcare Commission of all health care organisations. It lays down a common set of requirements to ensure that health services are provided that are safe and of an acceptable quality, as well as developing a framework for continuous improvement.

It is important that the health care organisation running each IPU can demonstrate that the core standards are met across all seven domains within *Standards for Better Health*:

- Safety
- Clinical and cost effectiveness
- Governance
- Service user focus
- Accessible and responsive care
- Care environment and amenities
- Public health

Furthermore, progress must also be made against the developmental standards in order to ensure that the service continues to meet the individual needs of its service users.

As part of the quality improvement process, IPUs need to be able to record performance monitoring data such as throughput, waiting times, and individual service user outcomes. In a mixed economy model, the predicted outcome will vary as a function of the range of treatment options provided (i.e. assessment, stabilisation, and assisted withdrawal). Thus, while process measures such as completion of the programme, service user satisfaction and successful onwards referral remain important components, there will be specific outcomes appropriate for each population determined by care plan objectives. There must also be a procedure for reflecting on these outcomes and using the data to continuously improve performance.

### Quality assurance: recommendations for the model service

- Each IPU must be integrated into a wider clinical governance structure to ensure that progress is made across all seven domains outlined in *Standards for Better Health*

- Progress towards the recommendations made in section 3 of this document should be continuously monitored through the clinical governance framework of the IPU parent organisation

- Standardised systems of data collection are important to allow audit of IPU data and monitoring of clinical standards

- Potential outcome measures:
  - For the stabilisation population, retention in treatment and continuing engagement with Tier 2 and Tier 3 services will be primary. Further outcomes will include measures reflecting continuing compliance with the care plan, including reductions in alcohol- or drug-related harm and improved psychosocial functioning and physical health
  - Dose assessment objectives will also include retention within the treatment journey and other longer-term outcomes
  - For abstinence-focused populations, including the 'early intensive assisted withdrawal' group, outcomes will include completion of rehabilitation programmes (day care or residential), ongoing abstinence and prevention of related subsequent harms

## Appendix 1 Case examples

### Case A

A is 33-year-old man, who is injecting cocaine on a daily basis and drinking a bottle of vodka a day. He is extremely frightened that the police are watching him, and he has presented to a Tier 2 agency asking for help.

*This man is in need of an urgent assessment of his mental state and his substance use. He may require a period of assisted withdrawal for alcohol dependence. He is then likely to need an extended period of treatment at Tier 3 level.*

### Case B

B is a 48-year-old bricklayer who is drinking at least 10 cans of nine per cent lager each day. He lives alone and is experiencing severe withdrawal symptoms when he wakes in the morning. He has developed mild jaundice and describes visual hallucinations that occur at least once a week. He was hospitalised following a fall from a ladder and was diagnosed as experiencing an alcohol-related seizure. He wants to stop drinking altogether and has attended a Tier 2 agency.

*There are a number of features suggesting that an assisted alcohol withdrawal program would be safest in an IPU environment. However, this would need to be linked seamlessly into a period of relapse prevention work and a comprehensive review of his other psychosocial needs.*

### Case C

C is a 33-year-old woman who has been receiving treatment from a community drug team for three years. In that time she has been on methadone and has stopped using heroin altogether (confirmed on saliva testing). She has reduced her methadone dose to 40ml per day. She has been assessed for, and obtained, funding for a residential rehabilitation placement. She wants to undertake an assisted withdrawal for opioid dependence.

*Community assisted withdrawal would be one option for this lady, but undertaking the process in a residential setting (either in an IPU or a suitably-equipped residential rehabilitation facility) could achieve the goal quicker and more effectively. A seamless passage to a residential rehabilitation setting would then be important.*

### Case D

D is a 26-year-old man who has been attending a community alcohol treatment service for a year. He has reduced his alcohol consumption, but is still heavily dependent and drinks a bottle of spirits each day. Symptoms of severe depression such as low mood, lack of energy and motivation have prevented him

attending the treatment service on a regular basis. There is a concern that he has had thoughts of harming himself.

*This man would clearly benefit from a period of close assessment of his mental state. However, his low mood is likely to be linked to his alcohol use, so an IPU may be the best place for this to occur. On completion of the assessment and assisted alcohol withdrawal he would return to the community service with a revised and enhanced care plan.*

### Case E

E is a 26-year-old woman who has been using heroin for more than 10 years. Every day, she uses nearly two grams of heroin intravenously. She has recently moved to the area and has approached a community service for treatment for the first time. She is unsure whether methadone will prevent her withdrawal symptoms.

*This woman has shown motivation to change for the first time and a priority will be to engage her in treatment. She is likely to need around 100ml methadone, and dose titration in the community using recommended safe rates of dose increase will take 3 weeks or more. An IPU admission for a week or so will allow a safe and more rapid titration up to the required level, while working to enhance her motivation and build engagement with the treatment process.*

### Case F

F is a 25-year-old woman with a two-year-old child. She has been receiving methadone maintenance for two years and is currently on 70ml a day. However, she continues to use heroin on a daily basis, as well as crack cocaine at least three times a week. She finds it hard to avoid contact with other drug users.

*This woman would benefit from an IPU admission to achieve a stabilisation goal in a safe and drug-free environment. Her opioid and stimulant withdrawal symptoms could be managed, her dose of methadone optimised and other prescribing arrangements could be reviewed. She could benefit from some psychological work around motivation and relapse prevention. Her social situation could be reviewed, and she could then return to community care with a new and enhanced care plan, or else plans could be made for further rehabilitation work in a residential setting.*

### Case G

G is a 26-year-old woman, pregnant with her first child. Prior to the pregnancy she was using one gram of heroin a day, and £20 worth of crack cocaine three times a week. She has started on a methadone maintenance programme, but continues to use heroin and cocaine intermittently.

*An admission to an IPU would allow G the opportunity to optimise her methadone programme and stop using illicit substances. A full assessment of the progress of her pregnancy could be made, and plans for the birth developed. The options for post-discharge care for mother and child after the birth could be considered and a plan developed.*

## Appendix 2 Epidemiological assessment of need for inpatient beds matched against the treatment journey

David Best and Ed Day, University of Birmingham

### Drugs

#### Model 1

The starting point for this discussion is the Royal College of Psychiatrists' assertion that for every 100,000 members of the total population, there should be three dedicated addiction beds[38]. We will assume that there should be an equal need for beds for primary drug and alcohol problems (although in subsequent models this is one of the assumptions that can be shifted) – so 1.5 beds per 100,000 or roughly 750 beds across England for drugs (based on a population of 50 million). This is equivalent (if you assume the nine regions are the same size) to 83.3 beds per region, a figure that is much higher than existing provision of specialist IPU beds, but may not be far away from the inpatient review finding of 796 beds (including general psychiatry and rehabilitation unit beds that are used for front-end assisted withdrawal)[5].

Therefore, if you assume that all the beds are used exclusively for assisted withdrawal (i.e. none for dose assessment or stabilisation) and that this will typically involve a planned stay averaging one month (although this may vary on the basis of individual need), each region should be doing around 1,000 inpatient assisted withdrawals a year – or 9,000 across the entire country.

#### Model 2

However, if you are assuming that each region should have a mixed economy of functions carried out within an IPU, then you will reduce the number of assisted withdrawals but increase the number of people able to attend, as typically both dose assessment and stabilisation will involve shorter periods of stay on the IPU.

If we revert to the DAT as the unit of analysis, and assume that there are typically just under 335,000 people resident in each DAT area, this would translate as 10 addiction beds, and so five drug beds available in each DAT area (assumptions about regional centres would not affect this basic calculation). These five beds can be translated into 250 IPT weeks available to the average DAT per year, based on the Royal College assumptions about levels of need (see above).

In this model we will assume that there are four potential purposes that IPU treatment can serve with drug users, and for this analysis we have estimated typical stays for each purpose (although these can be adjusted according to local population needs):

| | |
|---|---|
| 1. Assisted withdrawal to achieve abstinence in long-term dependent users | four weeks |
| 2. Assisted withdrawal for those early in their addiction careers | two weeks |
| 3. Dose assessment/titration | one week |
| 4. Stabilisation | two weeks |

*Note: These figures represent best guesses, and would be scaled up or down depending on the extent and complexity of pre- and post-discharge care services.*

In effect, these are the unit costs in a mixed economy model. So, if only traditional assisted withdrawals are done, then 62.5 service users can benefit from IPU treatment in the course of a year. If only 40 standard assisted withdrawal episodes are conducted, then 90 weeks is available for other usage (e.g. 20 stabilisation treatments, 20 early intervention assisted withdrawal episodes and 10 dose titration admissions).

### Model 3

The final model attempts to reconcile this decision-making process with an epidemiological needs assessment model, using the analysis conducted for the NTA needs assessment approach. The treatment flow assumptions are based on the three pilot sites investigated as part of the needs analysis process.

In this analysis, it is assumed that the "typical" DAT will have just over 2,000 problem drug users of whom around 1,400 will have contact with structured drug treatment in any given year. Typically, within that group there will be a stable treatment population who will have been consistently in treatment for at least one year.

### Further analysis of service user flow

To further analyse the flow of service users, we have additionally examined Birmingham service data to estimate the size of the population who may benefit from each of the four IPT options listed in Model 2:

*Treatment completion assisted withdrawal (i.e. assisted withdrawal to achieve abstinence in long-term dependent user)*

If we start with the assumption that of the 800 stable service users who have been in structured treatment for around one year, around 10 per cent are at the stage of their treatment career that it is legitimate to consider abstinence as an option, then in principle there would be 80 service users who could benefit for abstinence-oriented IPT as part of completing the treatment journey.

*Early career assisted withdrawal*

For the second group, we will use data from the QUAD study conducted in Birmingham[40]. Of 300 service users new to the community drug treatment services in 2002, around 40 per cent met criteria for potential early assisted withdrawal – they were using less than a gram of heroin, not injecting, did not have comorbid mental health problems and did not have multiple substance problems. Of this group, around 60 per cent were interested in pursuing a rapid assisted withdrawal process, rather than going into substitution programmes. Therefore, of around 300 new entrants to the treatment system, around 50 may benefit from early admissions and assisted withdrawals, although this assisted withdrawal process will be markedly shorter.

*Dose titration*

Similarly based on around 300 new entrants to the treatment system in the course of the year, it is estimated that around 10 per cent will be heavy problem users where the anticipated stable dose of methadone (or equivalent) will be around 100mg or more, and for this population inpatient dose titration may be appropriate and beneficial. Based on Birmingham data collected in 2003, there would be around 30 individuals would require this function[41].

*Stabilisation*

Data from a Birmingham service audit using the Christo Inventory (CISS)[42] found that around 10 per cent of existing service users (so around 80 individuals) had CISS scores of 13 or higher. For this population, an inpatient stabilisation and assessment period may be appropriate.

Thus, the optimal model, based on benefit, using the population assessments above, and based on the typical stay lengths discussed above for each function, would suggest a potential to benefit in a typical DAT area as shown in the table below:

| IPT function | Number of service users | Total IPT bed weeks |
|---|---|---|
| Treatment completion assisted withdrawal | 80 | 320 |
| Early career assisted withdrawal | 60 | 120 |
| Dose titration | 30 | 30 |
| Stabilisation | 80 | 160 |
| **Total** | **250** | **630** |

Thus, using this model, the typical DAT would be able to provide benefit from IPT to 250 individuals in a year. This would require a total resource of 13 drug beds per DAT area. However, the model could be scaled down and any of the assumptions changed (e.g. if typical assisted withdrawal length was three weeks rather than four for those reaching the end of their treatment journey, then two less beds would be required).

### Overview

This approach has been based on available information from the NTA and from Birmingham service data and analysis, but it would be important for each DAT area to undertake some similar analysis plugging in their own local information about treatment seeking populations, their career stage and their needs to assess the likely profile of beds required within each partnership area. Similarly, this does not mean that the beds have to be based within the area and local need could readily be translated into regional provision.

### Mapping the need for alcohol services

An example of an attempt to map the need for inpatient alcohol services comes from the work of Rush (1990)[43]. He used existing data from a number of Canadian provinces to extrapolate that 15 per cent of problem drinkers in Canada can be considered to be the treatment "target" group in any given year. This estimate was based on alcohol-related mortality data, national population survey data on drinking and population data on average consumption levels. The problem group in this area was calculated as 7.2 per cent of the population over the age of 15, or 8.6 per cent of the drinking population.

The model, based on a cohort of 10,000 problem drinkers, assumes that 1,500 (15 per cent) will request treatment in a given year, of whom two-thirds will make it as far as assessment. From this group, around 8.6 per cent of the original cohort will be referred to specialist services (867 individuals). Of this group, 55 per cent will be referred to outpatient services, 30 per cent to day treatment, 10 per cent to short-term residential treatment (i.e. IPUs) and 5 per cent to long-term residential treatment (i.e. rehab units). However, around 20 per cent will drop out from each treatment modality before completing treatment. A further four per cent of the original group will be directly referred to services (i.e. after emergency or criminal justice attendance), resulting in a total of around 950 individuals (or 9.5 per cent of the original 10,000) who will actually access specialist services, with the majority of these most appropriately dealt with in outpatient settings.

## Appendix 3 Working party and steering group membership

### Working Party membership

**Dr Ed Day** Consultant Addiction Psychiatrist, Birmingham and Solihull Mental Health NHS Trust

**Dr Jenny Bearn** Consultant Addiction Psychiatrist, South London and Maudsley NHS Trust, and Honorary Senior Lecturer, Institute of Psychiatry, King's College London

**Dr Francis Keaney** Consultant Addiction Psychiatrist, South London and Maudsley NHS Trust

**Dr Jane Marshall** Consultant Psychiatrist and Senior Lecturer in the Addictions, South London and Maudsley NHS Trust

**Dr Judith Myles** Senior Lecturer in Addictive Behaviour, St George's University of London, and Consultant Psychiatrist and Clinical Lead, Addictions, South West London and St George's Mental Health NHS Trust

**Dr Louise Sell** Associate Clinical Director and Consultant Addiction Psychiatrist, Bolton, Salford and Trafford Mental Health NHS Trust

### Steering Group membership

**Professor John Strang** Director, National Addiction Centre, Institute of Psychiatry, and South London and Maudsley NHS Trust (Chair)

**Dr Fleur Ashby** Consultant Addiction Psychiatrist, Barnsley Primary Care Trust

**Dr David Best** Senior Lecturer, University of Birmingham

**Mr Andy Bishop** Planning and Commissioning Manager, Hertfordshire County Council

**Dr Tom Carnwath** Consultant Addiction Psychiatrist, Tees, Esk and Wear Valley NHS Trust

**Ms Annette Dale-Perera** Director of Quality, National Treatment Agency (NTA)

**Dr Paul Davis** Consultant Clinical Psychologist, Camden and Islington Mental Health and Social Care Trust, and Chair of the Faculty of Addiction, British Psychological Society

**Prof Colin Drummond** Professor of Addiction Psychiatry and Honorary Consultant in Addiction Psychiatry, St George's University of London and South West London and St George's Mental Health NHS Trust, London, and SCAN Lead

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# Glossary

**Primary drug user** A person who may use alcohol but whose main problem is drug abuse or dependence.

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**Substitution programmes or non-abstinence focused treatment** Treatment that substitutes a prescribed drug (e.g. methadone) for an illicit drug (e.g. heroin), and in doing so reduces craving and prevents withdrawal symptoms. The removal of the preoccupation with finding and using illicit drugs allows the person to focus on other problem areas in their life and to make use of psychosocial and other treatment interventions.

**Comorbidity** The existence of other physical or psychological problems in addition to substance misuse.

**Assisted withdrawal** Assisted withdrawal is the process of withdrawing an individual from a psychoactive substance by providing medication and psychological support. This allows the process to occur in a relatively comfortable and controlled manner.

**Parenteral** Administration of a drug by intravenous, intramuscular or subcutaneous injection.

**Dose titration** The process of gradually adjusting the dose of a medication until the desired effect is achieved.

**Immunoassay screening and Gas Chromatography/Mass Spectrometry (GCMS)** Two very sensitive methods for detecting the presence of prescribed and illicit substances in urine or saliva.

**Christo Inventory for Substance Misuse Services (CISS)** The CISS is a simple standardised measure for monitoring outcome in substance misuse services. It is a 10-item questionnaire producing a single score of 0 to 20 which is a general index of service user problems / dysfunction.

**Wernicke-Korsakoff syndrome** A form of brain damage associated with alcohol misuse. The symptoms include confusion about time and place, drowsiness, poor balance, double vision, abnormal eye movements and ultimately memory loss. It is treated with large doses of thiamine (vitamin B1) by intravenous or intramuscular injection.

**Pharmacotherapy** Treatment with prescribed medication.


Royal College
of Psychiatrists


National Treatment Agency
for Substance Misuse